

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**London District**  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

<b>Original Public Report</b>	
<b>Report Issue Date: May 10, 2023</b>	
<b>Inspection Number: 2023-1178-0004</b>	
<b>Inspection Type:</b> Critical Incident System	
<b>Licensee: Omni Healthcare (Lambton) Limited Partnership, by its general partner, Omni Heal</b>	
<b>Long Term Care Home and City: Fiddick's Nursing Home, Petrolia</b>	
<b>Lead Inspector</b> Debra Churcher (670)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Terri Daly (115)	

<b>INSPECTION SUMMARY</b>
<p>The inspection occurred onsite on the following date(s): May 3, 4, 5, 8, 2023</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> <li>• Intake: #00012325 CIS# 2673-000053-22 related to a fall with injury.</li> <li>• Intake: #00015551 CIS# 2673-000060-22 related to a fall with injury.</li> <li>• Intake: #00016072 CIS# 2673-000063-22 related to responsive behaviors.</li> <li>• Intake: #00021054 CIS# 2673-000008-23 related to an injury of unknown cause.</li> <li>• Intake: #00021574 CIS# 2673-000010-23 related to a medication incident.</li> <li>• Intake: #00084367 CIS# 2673-000019-23 related to responsive behaviors.</li> </ul>

The following **Inspection Protocols** were used during this inspection:

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Responsive Behaviours

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Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting and Complaints

#### NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or might occur immediately reported the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

#### Rationale and Summary:

A Critical Incident System report (CIS) was received by the Ministry of Long-Term Care from Fiddicks Nursing Home for an alleged incident that occurred three days prior to the CIS report being submitted.

The report alleged that a resident reported an incident involving a co-resident. Cameras were reviewed and showed the co-resident entering the reporting residents room shortly before the allegation was reported.

A review of Omni Cares policy "Reporting Incidents of Abuse" Policy: #OP-AM-6.7, Reviewed/Updated: December 20, 2022 indicates the following:

#### POLICY

Each of the above noted incidents related to resident abuse shall be considered Mandatory Reports and, as such, shall be reported to the Director of Operations and the Ministry of Long Term Care by telephone and computerized submission of a Mandatory Critical Incident System (MCIS) form.

#### PROCEDURE

2. Immediate reporting of critical incidents to the Ministry of Long Term Care shall occur as follows:  
-Monday to Friday between 8:00 am and 4:30 pm by initiating a MCIS form online

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-After hours and Statutory Holidays by telephone to the After Hours number and submission of the MCIS form online within one day

An interview with the Director of Care (DOC), they indicated that they are aware of mandatory reporting and that they had not known about the alleged incident until three days after the incident occurred, when they submitted the Critical Incident (CI).

**Sources:**

CIS, reporting incidents of abuse policy and interview with the DOC.

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## WRITTEN NOTIFICATION: Medication Management

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 140 (1)

The Licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

**Rationale and Summary:**

Review of a resident's clinical record showed that the resident received eight medications that were meant for a co-resident.

The Director of Care (DOC) acknowledged that the resident was given medications that were not prescribed for them.

**Sources:**

Two resident's clinical records, and an interview with the DOC.

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