Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2014	2014_243504_0019	L-000673-14	Resident Quality Inspection

Licensee/Titulaire de permis

FIDDICK'S NURSING HOME LIMITED
437 FIRST AVENUE, P.O. BOX 340, PETROLIA, ON, N0N-1R0

Long-Term Care Home/Foyer de soins de longue durée

FIDDICK'S NURSING HOME
437 FIRST AVENUE, P.O. BOX 340, PETROLIA, ON, N0N-1R0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEIRDRE BOYLE (504), DONNA TIERNEY (569), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 17, 19, 20, 23, 24, 25, 26, 27, and 30, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the RAI Coordinator, Dietary Manager, a Cook, 1 Dietary Aide, Nurse Manager, Environmental Manager, Activation Manager, Executive Assistant, Physiotherapy/Restorative Care Coordinator, Maintenance staff, Nursing Coordinator, Behavioural Supports Ontario Personal Support Worker, 2 Registered Nurses, 7 Registered Practical Nurses, 11 Personal Support Workers, 1 Housekeeper, a student nurse, 3 Resident family members and 40+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all Resident home areas and common areas, medication room, observed Resident care provision, staff to Resident interactions, dining service, recreational activities, medication administration, medication storage areas, reviewed relevant Residents' health care records, posting of required information, relevant policies and procedures as well as minutes pertaining to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Observations of Resident #7455 bed with rails revealed a possible risk of entrapment.

In a separate room a resident's mattress appeared ill fitting with bed entrapment concerns. This was verified by the Registered staff.

Staff interview with Jody Brown - Physiotherapy/ Restorative revealed the beds had not been assessed and evaluated in accordance with evidence-based practices to minimize risks to the resident. This was confirmed by the Director of Care. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

On June 20, 2014 an interview with a resident's Power of Attorney revealed that items of a significant monetary value went missing and this was reported to the staff of the Home in 2013. The items have not been fully recovered to date.

Record review revealed a Resident/Family Concern Binder with 2 incomplete reports written for 2013 but none with respect to the resident's missing clothing. No policy outlining procedures for initiating complaints to the licensee could be found in the home's Policy and Procedure manual.

Staff interview on June 25, 2014 with a Personal Support Worker revealed she had no knowledge of a home policy outlining procedures for initiating complaints to the licensee.

Staff interview on June 24, 2014 with a Registered Staff revealed she had no knowledge of a home policy outlining procedures for initiating complaints to the licensee.

Staff interview with the Director of Resident Care confirmed that the home has no written policy outlining procedures for initiating complaints to the licensee and for how the licensee deals with complaints. [s. 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours any potential behavioural triggers and variations in resident functioning at different times of the day.

Interviews and observations indicated a resident was exhibiting responsive behaviours.

Through interview with the Registered Nurse, Registered Practical Nurse, Personal Support Worker/Behavioural Support Ontario member, and the Assistant Director of Care it was revealed that Resident #7458's plan of care does not include:

a) an assessment of the variations in behaviours throughout the day,

b) documentation of potential or actual triggers,

c) a recent interdisciplinary assessment of behaviours, the potential causes of the behaviours and their recommended interventions. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure each resident receives individualized personal care, including hygiene care and grooming.

Resident #7540 upper chest was observed by Inspector 569 and Inspector 504 to be unclean.

Resident #7540 was observed to be lying in an unclean bed. The resident was wearing an unclean shirt.

A family interview with Resident #7540 Power of Attorney revealed that the resident is frequently found in soiled clothing and bedding.

This was confirmed by Registered staff. [s. 32.]

2. The licensee failed to ensure that the resident received grooming on a daily basis.

From June 18 through to June 26, 2014 Resident #7435 had not been groomed. Interview with the Resident confirmed that they had not been groomed had not been offered assistance with grooming. This was confirmed by the Personal Support Worker.

A review of the home's personal care policy revealed that each resident who requires grooming will be offered assistance as required.

Interview with the Registered Practical Nurse confirmed that it is the home's expectation that residents are offered assistance with grooming as required. The resident had not been offered assistance daily as required. This was confirmed by the Assistant Director of Care. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Two unattended medication cups were observed on the dining room table in Fairbank dining room on Wednesday June 26, 2014 at 0745 hours. This was verified by a registered staff who confirmed that the expectation is that all medications are administered directly to the resident.

The Director of Care confirmed that leaving medications unattended on the table was not an acceptable practice and the expectation was that medications are administered directly to residents. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The care plan for Resident #7540 written in May, 2014 describes certain interventions.

The eMar for Resident #7540 for the month of June, 2014 describes contradicting interventions.

The Director of Care and RAI Coordinator confirmed that it is the home's expectation that the plan of care will set out clear directions to staff who provide direct care to the resident. The staff agreed that the documentation on the care plan is contradicting information to what is on the eMar and fails to set out clear direction. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident-staff communication response system could be easily seen, accessed and used by residents.

The call bell cord in the bathroom of resident #7475 was observed to be inaccessible to the resident. The call bell cord was positioned on the wall behind the toilet and to the right. The resident was unable to reach over to access the call bell. This was confirmed by the Personal Support Worker.

The call bell cord in the bathroom of resident #7435 was observed to be wrapped around the safety grab bar next to the toilet. When the call bell cord was pulled from that location, the switch did not engage to activate the call bell.

The call bell could not be easily used by the resident. This was observed and confirmed by the housekeeper. [s. 17. (1) (a)]

2. The Director of care confirmed that it is the home's expectation that the call bell in each residents bathroom is accessible and easily used by residents at all times. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Through observation of resident #7435 on June 17, 19, 20 and June 23-25, 2013 it was noted that the resident's lower teeth were unclean.

Through interview with the resident it was revealed that assistance is not provided to apply toothpaste to the toothbrush or with brushing their teeth.

The resident revealed that it is difficult to put toothpaste on the brush and it is a challenge to perform mouth care.

Documentation on the resident's care plan indicated that the resident is independent for oral care.

The resident advised the Inspector that the resident is not consistently capable of performing mouth care and would appreciate some assistance with mouth care.

The Personal Support Worker confirmed that the resident did not receive oral care in the morning.

Through interview with the Assistant Director of Care it was revealed that the

resident's care plan and Point of Care tasks state that the resident is independent for mouth care and should not be documented as being independent for mouth care.

The Assistant Director of Care confirmed that the resident had not been offered oral care in the morning and in the evening. [s. 34. (1) (a)]

2. The licensee failed to ensure that the each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

Through interview with the Registered Practical Nurse it was revealed that there was no documentation in the health record for residents #7486, # 7485, #7474, #7479 of having been offered an annual dental exam.

Interview with the Director of Care and the Assistant Director of Care confirmed that there is no policy or procedure in place to ensure that each resident is offered an annual dental exam.

Interview with the Executive Assistant revealed that each resident is offered a dental assessment on admission and confirmed that the home does not have a policy or procedure in place to ensure that each resident of the home is offered an annual dental exam. [s. 34. (1) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek out the advice of Family Council and Residents' Council in developing and carrying out the satisfaction survey and in acting on its results.

The residents participate in answering the questions on the survey, but not in the development of the survey. This was confirmed by Resident #7435 and by the Activity Director who sits as the licensee representative on Residents' council and by the Administrator. [s. 85. (3)]

2. Interview with a resident family member who attends the Family Council meetings regularly, revealed that the Family Council had not been consulted in developing and carrying out of the satisfactions survey.

Review of the minutes of Family Council revealed that there is no record of the advice of Family Council being sought out in developing the satisfaction survey.

Interview with the Programs Manager on June 25, 2014 and with the Administrator confirmed that the advice of Family Council had not been sought out in developing the satisfaction survey. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, that is secure and locked. Observations on June 25, 2014 at 0745 hours revealed a medication cart containing drugs on the Fairbank floor was unlocked and unattended. Registered staff confirmed the homes expectation is that the medication cart should be locked while it is unattended. Registered staff confirmed this medication cart containing drugs was not locked while it was unattended. [s. 129. (1) (a) (ii)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection control program.

A sit to stand lift #1 was observed in the hall on Victoria Way. The sit to stand lift was noted to be unclean and soiled with old debris of liquids and crumbs.

The Director of Care confirmed the homes expectation is that the lifts are wiped down in between residents requiring the use of the lift.

Medication administration, required a specific treatment. A Registered staff member re-used an alcohol swab before and after the treatment.

The Director of Care and the Assistant Director of Care confirmed that the expectation was that infection control practices were followed during this specific treatment. [s. 229. (4)]

2. On June 17, 2014, 2 unlabelled bottles of body lotion, 1 unlabelled hairbrush, 1 unlabelled comb, 1 unlabelled bottle of mouthwash and a basket filled with unlabelled personal care items were observed in the shared whirlpool tubroom. This was confirmed by the Personal Support Worker.

It is the home's expectation that all personal care and toiletry items in shared areas of the home are labelled. This was confirmed by the Director of Care. [s. 229. (4)]

Issued on this 9th day of July, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs