



**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2015	2015_216144_0052	023810-15	Critical Incident System

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 16, 2015

The inspection was related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, one Registered Practical Nurse and one Personal Support Worker.

One critical incident report and one resident clinical record were reviewed.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



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 LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

- s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
- (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
 - (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

- A) A fall assessment for one resident identified them as being at moderate risk for falls.
 - B) The resident experienced a fall after the above assessment was completed.
 - C) A post fall assessment identified the resident is low risk for falls.
 - D) The physician's current medication and treatment review revealed the resident was prescribed different classifications of medication that are options for identification on the fall assessment reports.
 - D) The resident's current quarterly assessment revealed the medication section of the assessment did not include the resident's use of the medications identified in the physician's medication and treatment review.
 - E) One Registered Practical Nurse (RPN) confirmed there have been no physician ordered changes to the classification of medications the resident is prescribed, the resident's quarterly assessment did not consider the different aspects of care for the resident and the assessment was not integrated, consistent and compliment the resident's care requirements.
 - F) The Director of Care (DOC) agreed the resident's medication record should have been considered and integrated into the current quarterly assessment. [s. 6. (4) (a)]
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Issued on this 18th day of September, 2015

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

Original report signed by the inspector.