



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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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
Apr 26, 2016	2016_260521_0010	009413-16	Complaint

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

REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 22, 2016.

This inspection pertained to a complaint of resident care.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), one Registered Practical Nurse (RPN), one Personal Support Worker(PSW), one Maintenance Manager, two residents and two family members.

A tour was completed of Ruby Hall wing; the inspector completed resident observations and reviewed relevant clinical records. One meal observation was completed and a review of a policy and procedure was also completed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).



Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

Observations revealed a resident room was cold with the window open to its maximum. The resident was in the bed and was cold to touch. There was no thermostat in the room.

Observations in the dining room revealed the thermostat setting was 21.7 degrees Celsius at the lunch time meal.

Observations of another resident room revealed the thermostat was set at 15 degrees Celsius.

An interview with a staff member revealed they were not aware of the regulated room temperature and “usually plays with the temperatures until the residents were happy”. The interview also revealed one thermostat controlled three resident room temperatures.

A review of Policy HS-002 Air Temperatures revealed the air temperatures were not to go below 22 degrees Celsius and the maintenance program would be responsible to obtain and document hallway temperatures daily as well as complete random room temperature checks and document based on a rotating schedule.

The staff member was unable to provide a record of any monitored room temperatures in the month of February, 2016.

An interview with the management confirmed the policy and procedure of Air Temperatures was not followed and it was the homes expectation that the policy and procedure of Air Temperatures should have been complied with. [s. 8. (1) (b)]



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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 any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act and is complied with, to be implemented voluntarily.

Issued on this 26th day of April, 2016

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

Original report signed by the inspector.