



**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 prévue le Loi de 2007 les foyers de soins de longue**

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 performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 21, 22, 27, 2012	2012_170203_0023	Critical Incident

**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**

CARMEN PRIESTER (203)

**Inspection Summary/Résumé de l'inspection**

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, and 3 Registered staff.

During the course of the inspection, the inspector(s) reviewed policies and procedures related to the critical incident, toured resident care areas and interviewed registered staff.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

<p><b>Legend</b></p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p><b>Legendé</b></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. 107. Reports re critical incidents**  
Specifically failed to comply with the following subsections:

- s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
  - 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
  - 3. A missing or unaccounted for controlled substance.**
  - 4. An injury in respect of which a person is taken to hospital.**
  - 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

The licensee did not ensure that the Director was informed of a critical incident no later than one business day after the occurrence of the incident.  
A period of several days passed between the date a critical incident occurred and the date it was reported to the Director.  
This was confirmed by the Administrator and the Director of Resident Care. [O.Reg79/10,s.107(3)3]

Issued on this 27th day of November, 2012



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prévus le Loi de 2007 les  
foyers de soins de longue**

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

A handwritten signature in cursive script that reads "Cameron Prust".