Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2020	2020_790730_0010	005679-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

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

Lambton Meadowview Villa
3958 Petrolia Line, R.R. #4 PETROLIA ON N0N 1R0

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

CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 10, 11, 15, and 16, 2020, as an off-site inspection.

The purpose of this inspection was to inspect the following intakes:
- Critical Incident (CI) M547-000003-20/ Log #005679-20 related to Falls Prevention and an unexpected death

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care (DONPC), and a Registered Nurse (RN).

The inspector also reviewed clinical records, and specific policies and procedures of the home.

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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, using the Ministry’s method for after hours emergency contact, of an unexpected or sudden death resulting from an accident.

The home submitted a specified Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) on a specified date related to an incident involving an identified resident four days prior. The resident was taken to hospital and died on the same day.

The licensee's policy "Reporting Critical Incidents-Ministry," stated that "critical incidents shall be reported according to the Long-Term Care Homes Act 2007." Appendix B "Table 2: Critical Incident Reporting under O Reg 79/10 subsections 107 (1) (3.1), and (7)" detailed that for an unexpected or sudden death to submit a report to the Director through the after hours reporting line and then to fill out a CIS form first thing the following business day.

A review of the progress notes in Point Click Care (PCC), for an identified resident, on a specified date, included an assessment, which detailed an incident involving the identified resident. The resident’s physician requested that the resident be sent to hospital. A further progress note on the same date noted that the home was notified by the hospital that the resident had died.

During an interview with Director of Nursing and Personal Care (DONPC) #101, they stated that the identified resident's death was an unexpected death. They said that the after-hours line was not called, as per their expectations. They said that they provided some additional training to staff as there was some confusion about how to report the incident, as staff had regarded it as an incident which resulted in a transfer to hospital instead of an unexpected death. They said that the incident was not reported immediately as per the MLTC's reporting requirements.

The licensee has failed to ensure that the Director was immediately informed of an identified resident's unexpected death using the Ministry’s method for after hours emergency contact. [s. 107. (2)]

Issued on this 17th day of June, 2020

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

Original report signed by the inspector.