

**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**London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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Facsimile: (519) 873-1300Bureau régional de services de
London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2020	2020_607523_0027	016310-20, 016625- 20, 017192-20, 017640-20	Critical Incident System

Licensee/Titulaire de permisThe 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**

ALI NASSER (523)

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): September 8 and 14, 2020.

This inspection was completed for the following Critical Incident System (CIS) intakes:

Log #016310-20, related to a resident's fall and change in condition.

Log #016625-20, related to a resident's fall, and change in condition.

Log #017192-20, related to a resident's fall, and change in condition.

Log #017640-20, related to a resident's fall, and change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker (PSW), two Physiotherapy Assistants (PTA) and a resident.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed 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.

2 WN(s)

1 VPC(s)

1 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>Légende</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 the procedure for the required Falls Prevention and Management Program was complied with for four residents.

O. Reg 79/10 s. 48 (1) required the home to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management" dated February 5, 2020.

The Policy required staff to complete a Comprehensive Post Falls Risk Assessments in Point Click Care.

A Comprehensive Post Fall Risk Assessments were not fully nor accurately completed for the four residents post multiple falls.

Director of Care reviewed the assessments and said that those assessments were not completed properly and accurately. DOC said it was expected that staff fully and accurately complete the post fall assessments, and that staff should have complied with the homes policy.

2. The licensee has failed to ensure that procedure for the required Falls Prevention and Management Program was complied with for a resident.

O. Reg 79/10 s. 48 (1) required the home to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management" dated February 5, 2020.

The policy required staff to complete a fall risk assessment within 24 hours of admission.

A clinical record review for a resident showed there was no fall risk assessment completed within 24 hours of admission.

DOC said the expectation was for the staff to complete the risk assessment within 24 hours of admission and for staff to comply with the home's policy.

Sources: the home's "Falls Prevention and Management" policy dated February 5, 2020; Comprehensive Post Fall Risk Assessments and DOC interview. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention interventions set out in a resident's plan of care was provided to the resident.

Review of resident's plan of care showed a specific falls prevention intervention to be implemented.

Observations showed that this intervention was not being implemented.

During an interview, a RPN said it was expected to have the intervention implemented as specified in the plan of care.

Sources: Resident's plan of care, observations and RPN interview. [s. 6. (7)]

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 the falls prevention interventions in a resident's plan of care is provided to the resident, to be implemented voluntarily.

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : ALI NASSER (523)

Inspection No. /

No de l'inspection : 2020_607523_0027

Log No. /

No de registre : 016310-20, 016625-20, 017192-20, 017640-20

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Sep 21, 2020

Licensee /

Titulaire de permis : The Corporation of the County of Lambton
789 Broadway Street, WYOMING, ON, N0N-1T0

LTC Home /

Foyer de SLD : Lambton Meadowview Villa
3958 Petrolia Line, R.R. #4, PETROLIA, ON, N0N-1R0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Angie Heinz

To The Corporation of the County of Lambton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # /

No d'ordre : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with O. Reg 79/10 s.8(1)(b).

Specifically the licensee must:

a) Comply with their Falls Prevention and Management Policy and implement a monitoring process to ensure that residents are assessed for fall risk within 24 hours of admission; and to ensure that the comprehensive post fall risk assessments are completed as per the home's policy.

b) A record of this monitoring process must be kept in the home including the dates it was completed, who completed it and any corrective action taken (if applicable).

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the procedure for the required Falls Prevention and Management Program was complied with for four residents.

O. Reg 79/10 s. 48 (1) required the home to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management" dated February 5, 2020.

The Policy required staff to complete a Comprehensive Post Falls Risk

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Assessments in Point Click Care.

A Comprehensive Post Fall Risk Assessments were not fully nor accurately completed for the four residents post multiple falls.

Director of Care reviewed the assessments and said that those assessments were not completed properly and accurately. DOC said it was expected that staff fully and accurately complete the post fall assessments, and that staff should have complied with the homes policy. (523)

2. 2. The licensee has failed to ensure that procedure for the required Falls Prevention and Management Program was complied with for a resident.

O. Reg 79/10 s. 48 (1) required the home to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention and Management" dated February 5, 2020.

The policy required staff to complete a fall risk assessment within 24 hours of admission.

A clinical record review for a resident showed there was no fall risk assessment completed within 24 hours of admission.

DOC said the expectation was for the staff to complete the risk assessment within 24 hours of admission and for staff to comply with the home's policy.

Sources: the home's "Falls Prevention and Management" policy dated February 5, 2020; Comprehensive Post Fall Risk Assessments and DOC interview. [s. 8. (1) (a), s. 8. (1) (b)]

An order was issued based on the following factors:

Severity: There was potential risk associated with this noncompliance as

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Pursuant to section 153 and/or
section 154 of the *Long-Term
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2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

multiple residents post fall assessments were not accurately nor fully completed.

Scope: The scope of noncompliance was widespread all four residents had assessments that were not accurately nor fully completed.

Compliance History: There was no previous non compliance with this section.
(523) (523)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Nov 30, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of September, 2020

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Ali Nasser

Service Area Office /

Bureau régional de services : London Service Area Office