

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor London, ON, N6A 5R2 Telephone: (800) 663-3775

	Original Public Report
Report Issue Date: September 12, 2023	
Inspection Number: 2023-1564-0004	
Inspection Type:	
Critical Incident	
Licensee: The Corporation of the County of Lambton	
Long Term Care Home and City: Lambton Meadowview Villa, Petrolia	
Lead Inspector	Inspector Digital Signature
Adriana Congi (000751)	
Additional Inspector(s)	1
Stacey Sullo (000750)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 7-8, 2023

The following intakes were inspected:

- Intake: #00094911 related to falls prevention and management; and
- Intake: #00095647 related to safe and secure home

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

Infection Prevention and Control Safe and Secure Home Falls Prevention and Management



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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On observation, the bedside transfer logo in the resident's room was not congruent with the transfer technique identified in the resident's plan of care. In interviews with staff, it was confirmed that staff were using the transfer technique identified in the plan of care.

A second interview with staff confirmed that they updated the bedside transfer logo as indicated in the care plan. On second observation, the bedside transfer logo was updated and reflected the resident's assessed transfer technique as directed in the resident's care plan.

Sources: Interview with staff; observations; Falls Prevention and Management Policy.

[000750]

Date Remedy Implemented: September 8, 2023