Ontario

**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

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| **Report Issue Date:** December 9, 2024 |
| **Inspection Number:** 2024-1564-0005 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** The Corporation of the County of Lambton |
| **Long Term Care Home and City:** Lambton Meadowview Villa, Petrolia |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27, 28, 2024

The following intake(s) were inspected:

- Intake: #00130062 - Critical Incident System report #M547-000052-24 - related to a fall with injury.

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

Infection Prevention and Control
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Required Programs

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the following interdisciplinary programs were implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 246/22, s. 11 (1) (b) states, 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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

**Rationale and Summary:**
A resident's clinical record showed the resident experienced an unwitnessed event.

Review of the resident's clinical record showed that the resident was to have a specific assessment at four specific times. Two of the assessments were incomplete and two of the assessments were not completed at all.

The homes policy stated that the registered staff will complete the specific assessment for a period of time after a specific incident.

During an interview with the Falls Lead they stated it was the expectation that the specific assessments would be completed in full.

Failure to complete the required assessments when required placed the resident at risk for an unidentified change in condition potentially delaying treatment.

**Sources:**
A resident's clinical record, interview with the Falls Lead and the homes specific policy.

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