Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 4, 2010	2010-144-9547-04Nov103304	CI Follow-Up L-01630 M547-000010-10

Licensee/Titulaire
The Corporation of the City 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, RR#4, Petrolia, ON N0N 1R0

Name of Inspector(s)/Nom de l'inspecteur(s)
Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident follow-up related resident abuse/neglect.

During the course of the inspection, the inspector spoke with one physician, the Administrator, Director of Care, one RPN, one PSW & the Food Service Supervisor.

During the course of the inspection, the inspector reviewed one critical incident report, one resident clinical record, the home abuse policy & one home suggestion, concerns & complaints form.

The following Inspection Protocols were used in part or in whole during this inspection:
Dignity, Choice & Privacy
Skin & Wound

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, s.3(1)4
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. Physician & Nurse Practitioner written orders related to wound treatments were observed to not be implemented for one resident the morning of November 4/10.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, s.6(10)(b)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

1. The plan of care for one resident was not reviewed & revised to address changes to the resident's care needs.

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WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, s.6(11)(b)
When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

1. The plan of care for one resident does not consider different approaches in the revision of the plan of care.

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WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, s.6(4)(a)
The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

Findings:

1. One resident has not been assessed by the Registered Dietician in response to development of a wound.
2. The Registered Dietician has not collaborated with staff & others involved in the different aspects of care of the resident.

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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 related to the Registered Dietician assessment of a resident & collaboration with staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, 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.

Findings:

1. The plan of care for one resident includes treatment for a wound. On the morning of November 4, 2010, it was observed that the care set out in the plan of care was not provided.

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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 related to the care set out in the plan of care being provided, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.26(3)15
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions.

Findings:

1. The Food Service Supervisor on interview confirmed one resident has not been assessed by the Registered Dietician.

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WN #7: The Licensee has failed to comply with O. Reg. 79/10 s.50(2)(iii)
Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Findings:

1. The Food Service Supervisor on interview confirmed one resident with wound has not been assessed by the Registered Dietician & nutrition & hydration changes related to the wound have not been implemented to the resident's plan of care.

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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 related to Registered Dietician assessment of resident's with altered skin integrity & any changes to the plan of care, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** G. McCarey
Title: **Date:**	**Date of Report:** November 18, 2010