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

Report Issue Date: April 26, 2023	
Inspection Number: 2023-1598-0001	
Inspection Type: Critical Incident System	
Licensee: Corporation of the County of Elgin	
Long Term Care Home and City: Bobier Villa, Dutton	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.04.26 13:20:07 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18 and 19, 2023.

The following intake was inspected:

- Intake #00020707 CI #M603-000001-23 related to Falls Prevention and Management.

The following intake was completed in this inspection:

- Intake #00002346 CI #M603-000010-22 related to Falls Prevention and Management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: CARE PLAN

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care had been revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Rationale and Summary:

A resident had an unwitnessed fall resulting in a transfer to hospital and a significant change in their health status. The resident was diagnosed with a specific injury and the resident returned to the home.

Review of the resident's clinical record showed discrepancies in a number of areas of documentation related to care needs, transfer aids and required interventions.

A staff member said they would find information related to the resident's care needs on the Kardex on POC and on the care board in the resident's room. They verified the resident's care needs had changed after the fall and required specific assistance with all care.

The Manager of Resident Care (MRC) reviewed the care plan and acknowledged these changes were missed and should have been care planned on the day of the assessment. The potential risk to the resident increased when their care plan was not revised to reflect the resident's current care requirements.

Sources: A Critical Incident System (CIS) report; the resident's clinical records; observations and interview with the MRC and other staff.