Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2019_532590_0002	002390-18, 017076-18, 025989-18, 033442-18	Critical Incident System

Licensee/Titulaire de permis

The 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

ALICIA MARLATT (590)

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): January 8 - 11, 14 and 15, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care, one Registered Nurse, three Registered Practical Nurses, four Personal Support Workers and three residents.

During the course of the inspection, the inspector(s) reviewed five residents' clinical records, Critical Incident System reports and internal investigation notes.

During the course of the inspection, the inspector(s) observed resident and staff interactions, resident rooms for specific interventions to be in place, infection prevention and control practices, the provision of resident care and the general cleanliness and maintenance of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: 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 had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term-Care (MOHLTC) reporting that resident #002 had fallen and was taken to the hospital for further assessment as they had sustained injuries. The resident returned from the hospital five days later.

Review of resident #002's care plan focused on falls prevention, which was updated when the resident returned from the hospital, showed that the resident used a hi-lo bed which was supposed to be in the lowest position when in use.

The inspector completed an observation of resident #002 on Jan 10, 2019, at 1415 hours. The inspector observed that the resident was sleeping in a hi-lo bed, however noted that the bed appeared to not be in the lowest position. The logo kept on the residents' wall that staff used for a quick reference, documented that the resident used a hi-lo bed, but did not have it checked off that the bed was to be in the lowest position.

The inspector requested that Personal Support Worker (PSW) #107 come and observe resident #002 in bed. It was observed that the resident was in a hi-lo bed and when asked if the bed was in the lowest position they said it was not. The PSW referred to the logo kept on the resident's wall, which did not indicate that the bed should be in the lowest position. The PSW stated that they used this logo as a quick reference to know if the bed should be kept low, if they used side rails and their transfer status. When asked who was responsible for updating the bedside logos, the PSW said that it was the registered staff; they completed their assessments and updated the residents' care plans and logos.

In an interview with Director Of Nursing and Personal Care (DONPC) #100, the inspector shared their observation and reviewed resident #002's care plan with them. They said that the registered staff were responsible for updating the logos in the residents' rooms, and that if the care plan stated the bed was to be in a low position when in use, then the bed should be low. The DONPC immediately initiated an audit of every residents' bedside logos to ensure that the logos were up to date and reflective of the assessments completed. [s. 6. (7)]

2. A CIS report was submitted to the MOHLTC reporting that resident#005 had fallen while in the bathroom and was taken to the hospital for further assessment.

Review of resident #005's progress notes showed that the fall happened during the night

shift. Resident #005 was being supervised on the toilet for safety by a PSW, until another resident had walked by resident #005's room who visibly required assistance from staff. The PSW had instructed resident #005 to stay on the toilet, that they would be back in a moment and quickly attended to the other resident that had walked by. Upon return to resident #005 moments later, the PSW found resident #005 on the floor in the bathroom.

Review of resident #005's care plan in place at the time of their fall, showed that it directed staff to not leave the resident unattended while on the toilet.

In an interview with DONPC #100, they shared that this was a very unfortunate incident and it was investigated. The PSW was forced to make a quick decision as to which resident to attend to, as there was not much staff on the night shift. The PSW thought that since resident #005 was already safely on the toilet, and they had instructed them to stay there, that they would be OK for a minute, which unfortunately was not the case as the resident had fallen regardless of the PSW's instruction. The DONPC said that the care plan did instruct staff to not leave the resident on the toilet alone and that the PSW monitoring the resident was aware of the care plan, but again with minimal staff, had to make a choice as to which resident to attend to. [s. 6. (7)]

3. A CIS report was submitted to the MOHLTC reporting an incident of resident to resident abuse. The report documented that resident #004 had wandered into resident #003's room, and resident #003 had pushed and punched resident #004, causing them to fall to the floor and resulting in injuries.

Review of resident #003's progress notes showed that the resident had a previous altercation with another resident approximately a month and a half earlier, when a resident had wandered into resident #003's room, however there were no injuries to either resident involved at the time. This incident was reported to the MOHLTC and in the CIS report it was documented that moving forward, new interventions were going to be implemented.
The progress notes surrounding the most recent incident, were reviewed. It showed a note documented by a registered staff member who wrote that the "residents' interventions for responsive behaviours were not actively in place" at the time of the incident.

Review of resident #003's care plan in place at the time of the incident showed that there was a focus on behavioural symptoms. The resident's behaviours were known to be triggered by co-residents when entering into their personal space and room.

In an interview with RPN #103, who was working the day of the incident, they shared that the interventions had not been in place at the specific time of the incident. The RPN said that they had observed the interventions in place several times during the morning while walking by. The RPN also shared that there were several residents that did wander on that unit, and they frequently misplaced things. The RPN recalled looking around the unit for the equipment for the interventions and had found them in a random spot on the unit, where obviously another confused resident had left them after removing them.

In an interview with Director of Nursing and Personal Care (DONPC) #100, they supported RPN #103 who was working that day and responded to the incident, and if the nurse said the interventions were not in place, then they were not. The DONPC recalled entering this intervention back in May into resident #003's care plan. The DONPC said that on that unit there were several residents who wandered freely with no issues. The interventions were easily removable by people other than staff members, including other confused residents.

The licensee had failed to ensure that the care outlined in resident #002, 005 and 003's plan of care, were provided to the residents. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a record kept under subsection (1) must be kept at the home for at least the first year after the resident was discharged from the home.

Ontario Regulation 79/10 r. 233. (1) directs that "Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home.".

A CIS report was submitted to the MOHLTC reporting a possible incident of neglect to resident #001.

In an interview with DONPC #100 the inspector had requested the home's internal investigative notes to review for the inspection. The DONPC shared that the current Administrator and themselves were not in their current positions when this incident occurred and could not answer any questions about the outcome of the incident. The DONPC and Administrator attempted to locate the notes completed by the previous DONPC, however were unable to find them. The current DONPC recalled the previous DONPC completing an investigation and asking staff questions, but was not part of the investigation, and did not know the results of the investigation. Both the DONPC and Administrator were aware of the regulations to keep records in the home for an identified period of time and did practice this themselves, however could not speak to the previous DONPC's practices, who they thought had taken the notes with them when they departed this home for other employment.

The licensee had failed to ensure that resident #001's records were kept at the home for at least the first year after the resident was discharged from the home. [s. 233. (2)]

Issued on this 24th day of January, 2019

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

Original report signed by the inspector.