Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Mar 26, 2021	2021_790730_0010	003638-21	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

CHRISTINA LEGOUFFE (730)

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): March 24 and 25, 2021.

The following Critical Incident System intake was completed within this inspection: Log #003638-21/ CI M547-000006-21 related to fall prevention.

An Infection Prevention and Control (IPAC) inspection was also completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Infection Prevention and Control (IPAC) Program Lead, Registered Practical Nurses (RPNs), and a Personal Support Worker (PSW).

The inspector also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) for a resident.

A resident was on contact and droplet precautions and signage was posted outside of the resident's bedroom indicating the precautions. The home's policy titled "Additional Precautions (Contact, Airborne, Droplet, Contact/Droplet), " which was part of the home's IPAC program, stated that contact precautions included gloves and a gown, which should be used for direct contact with the resident.

An Inspector observed a Registered Practical Nurse (RPN) administer medications and take a resident's temperature. The RPN was not wearing a gown or gloves at the time of the observation. During an interview, the RPN acknowledged that the expectation of the home was that they wore a gown and gloves during direct care with a resident on contact and droplet precautions and that they had not been worn the proper PPE when they provided care to the resident.

There was increased risk to the resident as a result of the RPN not wearing the correct PPE to provide care for a resident on contact and droplet precautions.

Sources: Observations; clinical records for a resident including progress notes; the home's policy titled "Additional Precautions (Contact, Airborne, Droplet, Contact/Droplet)" last revised February 2019; and interviews with an RPN and other staff. [s. 229. (4)]

Issued on this 26th day of March, 2021

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

Original report signed by the inspector.