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:** February 2, 2024

**Inspection Number:** 2024-1564-0001

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** The Corporation of the County of Lambton

**Long Term Care Home and City:** Lambton Meadowview Villa, Petrolia

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Stacey Sullo (000750) | Stacey Sullo Digitally signed by Stacey Sullo Date: 2024.02.05 08:43:27 -05'00' |

**Additional Inspector(s)**
Debra Churcher (670)
Terri Daly (115)

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 17, 22, 2024
The inspection occurred offsite on the following date(s): January 18, 19, 2024

The following intake(s) were inspected:

- Intake: #00095782: Allegation of resident-to-resident abuse.
- Intake: #00097185: Allegations of neglect of resident by staff.
- Intake: #00098482: COVID-19 Outbreak.
- Intake: #00098750: Incompetent/improper treatment of resident by staff.
- Intake: #00105080: Fall of resident with injury.

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The following intakes were completed in this inspection:

- Intake: #00091902, Intake: #00093224, intake: #00093506, intake: #00097230, intake: #00099254, and intake: #00104247, were related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect resident from neglect by staff.

**Rationale and Summary:**
For the purposes of the Act and this Regulation,

O. Reg. 246/22 states, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of resident's clinical record showed that the resident was found by a staff member, in the washroom for an extended period of time.

During an interview with staff they acknowledged that the failure of the PSW to check on resident for an extended period of time constituted neglect.

The homes failure to follow up with the resident within a timely manner after they were assisted to the bathroom placed the resident at risk for not receiving required care and assistance.

**Sources:**
Resident clinical record, the home's internal investigation and interviews with staff.

[670]

## WRITTEN NOTIFICATION: RECORDS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 281 (1) 1.**
Records, where kept
s. 281 (1) Every licensee of a long-term care home shall ensure that the following records are kept at the home:
1. The records of current staff members.

The licensee has failed to ensure that the records of current staff members were kept at the home.

**Rationale and Summary:**
Employee file was requested for review. Staff shared that employee files are kept offsite. The employee file was received the next business day.

**Sources:**
Interview with staff.

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