

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: June 27, 2024	
Inspection Number: 2024-1564-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Lambton	
Long Term Care Home and City: Lambton Meadowview Villa, Petrolia	
Lead Inspector Stacey Sullo (000750)	Inspector Digital Signature
Additional Inspector(s) Cassandra Snedden (000832)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 14, 17, 18, 2024

The following intake(s) were inspected:

- Intake: #00113981 - CI#: M547-000019-24- Responsive behaviors between residents.
- Intake: #00118442 - CI#: M547-000036-24- Responsive behaviors between residents.
- Intake #00113093, CI#: M547-000016-24- Resident fall with injury.

The following intake was completed in this inspection:

- Intake #00110347, CI#: M547-000008-24- related to resident fall.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) 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.

The licensee has failed to ensure that resident #004's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary

Resident #004's care plan stated an intervention for responsive behaviours.

During an interview with staff, who confirmed that resident #004 was required to have an intervention in place for their responsive behavior, however staff acknowledged the resident's care plan had not been updated to include the responsive behavior intervention and agreed to update immediately.

Inspector confirmed staff had revised resident #004's care plan with the responsive behaviour intervention.

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There was a low risk and low impact to resident #004, as resident's care plan was not reviewed and revised when their care needs changed.

Sources

Review of resident #004's care plan, and interview with DOC #101.

[000832]

Date Remedy Implemented: June 18, 2024

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WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to ensure that the steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #004 and others were identified and implemented.

Rationale and Summary

Resident #004 had a responsive behavior, and staff confirmed resident was to have an intervention in place to support their need. Staff acknowledged that resident #004 did not have their responsive behavior intervention in place at the time of incident. Resident #004's progress note stated that resident was to have their responsive behavior implemented.

There was a moderate risk and moderate negative impact to resident #004 as their responsive behavior intervention was not implemented at the time of incident.

Sources

Resident #004's progress notes and interview with staff.

[000832]