

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 15, 2024	
Inspection Number: 2024-1598-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Corporation of the County of Elgin	
Long Term Care Home and City: Bobier Villa, Dutton	
Lead Inspector Stacey Sullo (000750)	Inspector Digital Signature
Additional Inspector(s) Debra Churcher (670)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 8, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00108633 - M603-000002-24 Alleged resident to resident abuse.
- The following intakes were completed in this inspection: Intake #00102669, CI#M603-000018-23 and Intake #00104832, CI#M603-000022-23, and intake #00105725.

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

- Skin and Wound Prevention and Management
- Infection Prevention and Control
- Responsive Behaviours
- Reporting and Complaints
- Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee failed to ensure that an assessment was completed for the required assessment intervals.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure the home's policy was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's policy.

Rationale and Summary:

After review of resident's assessment there were only three documented assessment times in which staff charted assessing resident.

The staff acknowledged in an interview that the assessments were not completed as expected for resident, and the resident should have been assessed per the homes policy.

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Sources:

Resident's chart, staff interviews, and the homes policy.

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WRITTEN NOTIFICATION: Skin and Wound Care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure a resident's skin injuries were reassessed and monitored at least weekly.

Specifically, staff did not complete follow up skin assessments on resident.

Rationale and Summary:

Progress note documented that resident was assessed by registered nursing staff to have injuries.

After review of resident's chart, no assessments were completed.

The staff acknowledged in an interview that the assessments were not completed or documented on weekly as expected by registered staff for resident.

Sources:

Resident's chart, and staff interviews,

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