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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016	2016_277538_0017	020843-16 009027-16	Complaint

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

NORTH LAMBTON LODGE
39 Morris Street R.R. #6 FOREST ON N0N 1J0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 25, 2016.

Complaint inspection IL-45612-LO, IL-43720-LO was related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, one Registered Nurse, one Personal Support Worker, one Confidential Secretary, one Volunteer Coordinator, one Resident Assessment Instrument Coordinator, one Life Enrichment Coordinator, one Volunteer and one resident.

The inspector also observed care and activities provided to residents, resident/staff interactions, reviewed clinical records and plans of care for the identified resident, reviewed the home's investigation notes and relevant policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.

- **1 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	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm immediately reported the suspicion and the information upon which it was based to the Director.

Record review of the progress notes for an identified date, revealed documentation of a meeting between the Social Worker (SW) and a specified resident. Further record review indicated that a meeting was held on an identified date, between the Director of Nursing (DOC) and the Social Worker to inform the DOC about the incident.

Record review of the home's policy for prevention of Abuse and Neglect to Residents dated July 2015, stated "immediately upon becoming aware of the incident, the Administrator or designate will notify the Ministry of Health and Long Term Care." There was no documented evidence that the DOC and the Administrator notified the Ministry of Health and Long Term Care immediately after becoming aware of the incident.

During a staff interview, the Administrator acknowledged that they were made aware of the incident and agreed that they did not immediately inform the Ministry of Health and Long Term Care of the alleged abuse. The Ministry had not been notified at the time of the inspection. [s. 24. (1)]

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 when a person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 31st day of August, 2016

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

Original report signed by the inspector.