

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

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité London Service Area Office 130 Dufferin Avenue 4th floor LONDON ON N6A 5R2 Telephone: (519) 873-1200 Facsimile: (519) 873-1300 Bureau régional de services de London 130 avenue Dufferin 4ème étage LONDON ON N6A 5R2 Téléphone: (519) 873-1200 Télécopieur: (519) 873-1300

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Report Date(s) /	Inspect
Date(s) du apport	No de l'

tion No / Log # / l'inspection Registre no

May 21, 2015 2015_418615_0011 006605-14

Type of Inspection / Genre d'inspection Critical Incident System

Licensee/Titulaire de permis THE CORPORATION OF THE COUNTY OF LAMBTON 789 Broadway Street WYOMING ON NON 1T0

Long-Term Care Home/Foyer de soins de longue durée

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

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 14, 2015

This Critical Incident inspection is related to incident M559-000010-14.

The Critical Incident is related to Prevention of Abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, two residents, two Personal Support Workers and one Registered Nurse.

The Inspector also made observations, reviewed health records, policies, the home investigation and other relevant documentation.

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) 0 VPC(s) 0 CO(s) 0 DR(s)
- 0 WAO(s)



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order 	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 20. Policy to promote zero tolerance



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Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).

(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).

(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).

(e) shall contain procedures for investigating and responding to alleged,

suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :





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1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect is complied with.

The home's policy, Prevention of Abuse and Neglect to Residents, 2-8-18 indicates the following: Immediately upon becoming aware of the incident, the Administrator or designate will notify the Ministry of Health and Long-Terms Care Monday to Friday between 0800 to 1700 hours by initiating the online form using the mandatory report section.

Review of the Critical Incident indicated the incident occurred on a specific date and was not submitted to the Ministry of Health (MOH) until a later date.

The Director of Care confirmed that the incident was not reported to the MOH by the designate immediately.

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports by reporting immediately to the Director.

The home's policy, Prevention of Abuse and Neglect to Residents, 2-8-18 indicates the following: Immediately upon becoming aware of the incident, the Administrator or designate will notify the Ministry of Health and Long-Terms Care Monday to Friday between 0800 to 1700 hours by initiating the online form using the mandatory report section.

Review of the home's policy, Prevention of Abuse and Neglect to Residents, 2-8-18 revealed no directions on reporting immediately to the Ministry of Health outside of those hours.

The Director of Care confirmed that the home's policy did not include an explanation of s. 24 to report immediately. [s. 20. (2)]



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Issued on this 22nd day of May, 2015

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

Original report signed by the inspector.