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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_797740_0008	005015-19, 005019-19	Critical Incident System

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

SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 24, 25, 26, 2019.

The following intakes were completed within the Critical Incident Systems inspection:
Log# 005015-19 / CI# M559-000001-19 related to allegations of staff to resident abuse; and
Log# 005019-19 / CI# M559-000002-19 also related to allegations of staff to resident abuse.

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

The inspector(s) also made observations and reviewed residents' clinical records.

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)**

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	Légende 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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident the licensee suspected may constitute a criminal offence. r. 98.

Critical Incident System (CIS) #M599-000001-19/ Log #005015-19 was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC), related to an allegation of staff to resident physical abuse causing pain.

The North Lambton Lodge "Prevention of Abuse and Neglect to Residents Policy" #2-8-18 stated, in part, that the Administrator would notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

The CIS report stated in part, "There was an allegation of physical abuse of resident #001 by PSW #102 – physical force was used to remove the resident's clothing causing the resident pain".

Resident #001 stated in an interview, that staff member #102 was rough with them and grabbed their arms. They said, they thought the staff member was going to get worse with their roughness and felt they had been abused.

Director of Care (DOC) #107 stated in part, the treatment of resident #001 by staff member #102 described by staff member #103 was considered physical abuse and DOC #107 stated, the police should have been called."

The licensee failed to immediately notify the appropriate police force of the allegation of physical abuse to resident #001. [O. Reg. 79/10, s. 98.] [s. 98.]

Issued on this 22nd day of May, 2019

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

Original report signed by the inspector.