

Ministère de la Santé et des Soins

de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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**

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Public Copy/Copie du public

Report Date(s) /

Inspection No / Date(s) du Rapport No de l'inspection Loa #/ No de registre

Type of Inspection / **Genre d'inspection**

Jul 24, 2019

2019_563670_0021 012031-19

Complaint

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 **DEBRA CHURCHER (670)**

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 15, 2019.

The following complaint inspection was completed.

Log# 012031-19 IL-67649-LO related to falls prevention and failure to post required inspection reports.

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

During the course of this inspection the Inspector also observed the overall maintenance and cleanliness of the home, observed staff to resident interactions, the provision of care, reviewed the applicable internal documents and completed applicable record review for the identified residents.

The following Inspection Protocols were used during this inspection: Falls Prevention

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)



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Légende
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. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants:



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1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The Long-Term Care Homes Act, 2007, s. 79. (3) (k) states, the required information for the purposes of subsections (1) and (2) is, (k) copies of the inspection reports from the past two years for the long-term care home.

The Ministry of Long Term Care received a complaint on a specific date, related to a concern that staff had not made a specific device available to resident #001 as per the plan of care and that the home was not posting two years of inspection reports.

On July 15, 2019, upon entering the home, Inspector #670 noted posted inspection reports for complaint inspection #2019_563670_0014, report date May 1, 2019, and Critical Incident System inspection #2019_797740_0008, report date May 10, 2019.

The Administrator #102 stated they had just removed multiple reports from the board as they were all beyond two years old.

The Administrator #102 later returned and informed Inspector #670 that they had reviewed the reports that they had removed and noted they had inadvertently removed Resident Quality Inspection report #2017_678680_0014, report date November 15, 2017, and had re-posted the report.

Review of the home's inspection history showed the following inspection reports that were not posted;

- -Critical Incident System inspection #2017_678680_0015, report date February 22, 2018.
- -Critical Incident System inspection #2018_533115_0011, report date June 28, 2018.
- -Critical Incident System inspection #2018_607523_0020, report date August 1, 2018.
- -Critical Incident System inspection #2019_609569_0003, report date February 26, 2019.

The Administrator #102 stated that they had started at the home in May of 2019 and did not know why all the required inspection reports were not posted and acknowledged that they should have been.

The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted. [s. 79. (1)]



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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 the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations, to be implemented voluntarily.

Issued on this 24th day of July, 2019

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

Original report signed by the inspector.