Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: June 16, 2023	
Inspection Number: 2023-1572-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Corporation of the County of Lambton	
Long Term Care Home and City: North Lambton Lodge, Forest	
Lead Inspector Melanie Northey (563)	**Inspector Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2023.06.19 09:20:42 -04'00'
Additional Inspector(s) Meagan McGregor (721) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6, 7, 8, 9, 12, 13, and 14, 2023

The following intake(s) were inspected:

- Intake: #00088688 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 19

The licensee failed to ensure that a window in the home that opened to the outdoors could not be opened more than 15 centimetres (cm).

Rationale and Summary
A window was opened in a resident room. The hinge on this window appeared to be in a state of disrepair and the window opened to 36 cm.

Maintenance staff members indicated that windows in the home had stoppers to prevent them from opening more than 15 cm. They said they were unaware that the window in the resident room opened to more than 15 cm and suspected the stopper was not working properly and a work order would be submitted to fix this window.

The hinge on this window appeared to be repaired and the window did not open more than 15 cm. The risk to resident's safety was low as the room was located on the ground level of the home and the area outside the resident's room was a secured courtyard.

Sources: Observations conducted in the home; and staff interviews. [721]
Date Remedy Implemented: June 7, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that the rights of residents to have their personal health information (PHI) kept confidential in accordance with that Act was fully respected and promoted.

Rationale and Summary
During an observation of the medication administration, a Registered Practical Nurse (RPN) threw the

residents labelled medication strip packages in the main garbage at the side of the medication cart. The RPN stated nothing was added to the garbage bag to remove PHI from the strip packaging. The RPN explained the labeled medication packages were thrown in the medication cart garbage, the garbage was then collected and added to general garbage, and they were not told to remove PHI before disposal.

The Director of Care stated there was no practice in place to remove PHI from strip packs before general disposal.

Sources: Medication Disposal Policy, observations and staff interviews.
[563]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including all areas where drugs were stored shall be kept locked at all times when not in use.

Rationale and Summary
During an observation of a medication storage area accompanied by a Registered Practical Nurse (RPN), the medication cart was observed unlocked and accessible and the controlled substance drawer within the medication cart was also unlocked. Inspector #563 was able to open all drawers and narcotic storage without a key. The RPN verified the drug supply was not secured and locked at all times when not in use and the RPN demonstrated that the medication cart was unlocked and did not require a key to open the controlled substance drawer.

The Director of Care stated the medication cart was to be locked at all times when not in use and all controlled substances were to be double locked in the medication cart. All areas where drugs were stored were not kept locked at all times, when not in use.

Sources: Safe Storage of Medications Policy 4.8, observations and staff interviews.
[563]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2. i.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including access to these areas restricted to persons who may dispense, prescribe or administer drugs in the home.

Rationale and Summary
During an observation of a medication storage area, a Registered Practical Nurse (RPN) entered the nursing office, the door was open and accessible, and retrieved their keys and swipe card to open the medication room door and medication cart. The RPN verified the keys were left unattended in the nursing office in an open area accessible to anyone.

The Director of Care stated all the registered nursing staff had access to the medication rooms using a swipe card system, and the expectation related to the ownership of the swipe card was for the registered nursing staff to keep it on their person at all times.

Sources: Safe Storage of Medications Policy 4.8, observations and staff interviews.
[563]

WRITTEN NOTIFICATION: 001

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (3) 3.

Rationale and Summary
The licensee failed to ensure that the continuous quality improvement (CQI) committee fulfilled their responsibilities to coordinate and support the implementation of the CQI initiative, including preparation of the report on the CQI initiative.

The home formed a CQI committee prior to July 2022, however this committee did not meet for the first time until December 2022. Prior to the first CQI committee meeting in December 2022, the designated lead of the home's CQI initiative was independently responsible for coordinating and supporting the implementation of the CQI initiative, including preparing the report on the CQI initiative.

Sources: Review of the home's CQI meeting minutes and staff interviews with the Administrator and Quality Assurance Manager. [721]