

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: May 8, 2025

Inspection Number: 2025-1572-0002

Inspection Type:

Critical Incident

Licensee: The Corporation of the County of Lambton

Long Term Care Home and City: North Lambton Lodge, Forest

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 & 8, 2025

The following intake(s) were inspected:

- Intake: #00144342 / CI #M559-000008-25 related to outbreak management

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023 was implemented. Specifically, the licensee failed to ensure that section 9.1 and 10.2 were followed.

A) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023 was implemented. Specifically, the licensee failed to ensure that residents were provided assistance to perform hand hygiene before meals.

The IPAC standard states under section 10.2:

The hand hygiene program for residents shall include:

c) Assistance to residents to perform hand hygiene before meals and snacks

In an observation of a meal service, it was noted that residents were not provided assistance or supported to perform hand hygiene before their meal.

The Infection Prevention and Control (IPAC) lead confirmed they would expect staff to assist residents with hand hygiene before each meal.

Sources: Dining observation, interview with the IPAC lead, review of the home's hand hygiene policy

B) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023 was implemented. Specifically, a member of the registered staff failed to perform hand hygiene

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according to the four moments of hand hygiene between contact with different residents.

Section 9.1 of the IPAC standard states that routine practices and additional precautions are to be followed in the IPAC program, which includes:
b) hand hygiene before initial resident/resident environment contact and after resident/resident environment contact

A registered staff member was observed to provide care to residents without performing hand hygiene between resident contacts. The IPAC lead confirmed the expectation was that hand hygiene would be completed between resident contact according to the four moments of hand hygiene.

Sources: Observations, interview with the IPAC lead, and review of the home's medication administration and documentation policy

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the written policies related to medication management were implemented.

Specifically, a registered staff member did not implement the home's policy titled "The Medication Pass, Section 5: Medication Administration and Documentation

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which was included in the home's Medication Management Program. The policy stated that during a medication administration, staff should observe the resident to ensure that medication had been swallowed, ensure that the resident had taken all scheduled medications, and then complete the required documentation.

A registered staff member was observed providing multiple resident's with medications for self-administration. The registered staff member did not wait to ensure that the resident's had taken all scheduled medications prior to completing the required documentation.

The registered staff member acknowledged that they had documented the administration prior to ensuring the resident's had taken the medication.

Sources: Observation, interview with a registered staff member and the Administrator, review of the home's policies, and review of resident clinical records

COMPLIANCE ORDER CO #001 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (6)

Administration of drugs

s. 140 (6) The licensee shall ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee must:

A) Provide re-training to the registered staff member related to medication administration, including, but not limited to the home's Self-Administering Resident's policy as it relates to

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resident self-administration with a physician orders. The home is to maintain a record of the education provided, including the education content, who provided the training, and the date the training was completed.

B) Develop and implement a weekly audit to ensure that the registered staff member does not provide medication to residents for self-administration without a physicians order, until this compliance order is complied by an inspector. The home must maintain a documented record of the audits, including the date, what was observed, any inconsistencies, and corrective action taken.

Grounds

The licensee has failed to ensure that multiple residents did not administer a drug to themselves unless the administration had been approved by the prescriber.

A registered staff member was observed providing medications to multiple residents. The registered staff member did not wait with the residents to ensure that the medications were taken as prescribed.

The home's Self-Administering Resident's policy, indicated that a resident was able to self-medicate when an physician order was written. The home's Medication Administration and Documentation policy indicated that residents were to be observed to ensure that the medication had been swallowed and was recommended for staff to verify that the resident had ingested the medication.

The noted resident's did not have a physicians order for self-administration of medications in their clinical records.

There was risk to residents related to medication administration when they were not observed taking their medication as per physician orders.

Sources: Observation, interview with the registered staff member and the Administrator, and review of the home's policies and procedures

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This order must be complied with by June 20, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor

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Director

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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.