Ontario

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

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

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

Public Report

Report Issue Date: July 22, 2025
Inspection Number: 2025-1572-0003
Inspection Type: Critical Incident Follow up
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): July 15-17, and 22, 2025

The following intakes were inspected:

- Intake #00147059/Follow-up #1 to CO #001/2025-1572-0002, O. Reg. 246/22 s. 140 (6), administration of drugs; and
- Intake #00149954/Critical Incident (CI) #M559-000013-25 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1572-0002 related to O. Reg. 246/22, s. 140 (6)

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

Medication Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The resident had a physician's order in place for a scheduled medication which directed staff to hold administration of the medication under specific circumstances. An incident occurred with the resident and the physician ordered this medication to be held for a period of time after the incident. A registered staff member subsequently administered the residents scheduled dose of this medication in the period of time following the incident when the physician had ordered the medication to be held.

Sources: the resident's clinical record, including their care plan, progress notes, orders, Medication Administration Record (MAR), and head injury routine; observations of the resident and their condition; and staff interviews.