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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2018	2018_554541_0012	018308-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Lanark
c/o Lanark Lodge 115 Christie Lake Road PERTH ON K7H 3C6

Long-Term Care Home/Foyer de soins de longue durée

Lanark Lodge
115 Christie Lake Road, R. R. #4, Lot 27, Concession 2 PERTH ON K7H 3C6

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

AMBER LAM (541), CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 9-10 and 13-17, 2018.

The following intakes were completed concurrently with this inspection:

Log #025019-17, CIS #M548-000023-17: a fall with a significant change in condition
Log #003655-18, CIS #M548-000002-18: a fall with a significant change in condition
Log #029114-17, CIS #M548-000027-17: a fall with a significant change in condition
Log #014157-18, CIS #M548-000014-18: a fall with a significant change in condition
Log #005783-18, CIS #M548-000006-18: a fall with a significant change in condition
Log #027604-17, CIS #M548-000026-17: a fall with a significant change in condition

During the course of the inspection, the inspector(s) spoke with Acting Director, the Director of Care, the Environmental Services Manager, a programming staff member, a scheduling clerk, Registered Practical Nurses, Personal Support Workers, the chair of the Family and Friends Council, the President of the Residents' Council, family members and residents. In addition the inspectors conducted a tour of the home, observed staff to resident interactions, reviewed resident health care records, relevant policies, registered staff schedules and observed medication administration.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for resident #023.

This finding is related to critical incident log #025019-17 in which resident #023 fell and sustained an injury. The incident occurred on a specified shift when the resident was not in bed during rounds, but was found on the floor in a specified tub room. The tub room door was open but the pocket door was closed behind the resident and the lights were off. The resident had been incontinent and there was some emesis on the floor. Upon assessment, it was noted that the resident had an injury and was complaining of pain. The resident was sent to the hospital and admitted with a specified injury.

During an interview with Inspector #641 on August 16, 2018 at 1110 hours, PSW #112 indicated having worked on the unit at the time that resident #023 was in the home. The PSW advised that resident #023 would wander about the unit but had not been known to fall. PSW #112 thought that the resident had a bed alarm on the bed at the time, to alert the staff when the resident was getting up in the night. PSW #112 specified that the reason why the tub room door may have been unlocked was that when the last person came out of the room, the door may not have latched closed completely, leaving it ajar. PSW #112 demonstrated to the Inspector that the door had since been repaired so that it couldn't remain open, but now closed properly.

Inspector #641 interviewed RPN #104 on August 16, 2018 at 1345 hours. The RPN indicated having worked the shift that resident #023 had fallen in the tub room and advised that there had been a staff member on the unit who hadn't worked there very often. When the staff were doing their rounds, resident #023 was not in bed and was found on the floor in the tub room. RPN #104 advised that it was possible that when the other staff left the tub room earlier that shift, the door didn't close properly, otherwise resident #023 would not have been able to get in the tub room. RPN #104 advised that the tub room door should be locked at all times.

During an interview with Inspector #641 on August 16, 2018 at 1415 hours, the Director of Care, (DOC) indicated that the tub room door should always be locked and that their understanding of the events on the night of the incident was that the door had not closed properly so that it didn't lock, therefore allowing resident #023 to enter the room unattended. The DOC indicated that since that evening, the door had been repaired so that it automatically closed completely each time it was opened.

The licensee failed to ensure that the tub room door was locked to ensure a safe and secure environment for resident #023. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in resident #001's plan of care.

On two specified dates during the inspection, Inspector #641 observed resident #001 lying in bed with two ¾ length bed rails in the up position.

Inspector #641 reviewed resident #001's care plan which stated "one side rail; bed is against the wall. Ensure the side rail against the wall is up at all times."

During an interview with Inspector #641 on August 13, 2018 at 1425, PSW #103 indicated that resident #001 did have two bedrails since the resident was cognitively impaired and would try to get up and out of bed if they weren't up. PSW #103 specified that if the resident tried to get out of bed, the rails would prevent the resident from getting up.

Inspector #641 interviewed RPN #102 on August 13, 2018 at 1430. RPN #102 indicated that resident #001 was currently bedridden. The RPN advised that resident #001 had two long rails that were up since the resident liked to sleep on their side, close to the edge of the bed. RPN #102 specified that the rails would prevent the resident from getting out of bed if the resident attempted to.

During an interview with Inspector #641 on August 15, 2018 at 1015, the Director of Care (DOC) indicated that the licensee did not have any full rails in the home but did use ¾ rails on some of the beds. The DOC advised that if the resident had two ¾ rails in the up position, this would be considered a restraint and would require a doctor's order and consent from the resident's substitute decision maker (SDM).

The licensee failed to ensure that resident #001's plan of care identified the use of two ¾ bed rails which restrained the resident from getting out of bed. [s. 31. (1)]

2. The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraint by a physical device for resident #001.

Inspector #641 reviewed resident #001's health care record on August 14, 2018. There was no evidence of documentation of a doctor's order for two ¾ bed rails.

During an interview with Inspector #641 on August 14, 2018 at 1400, RPN #104 indicated that resident #001 did not have a physician's order for the two bed rails and that an order would be required in order to use them both. The RPN advised that the resident was only to use one rail and that prior to a change in health status, the bed was against the wall and so the resident had a rail up on the wall side. At some point since August 8, 2018, the resident's bed was moved away from the wall and the staff were now putting the other rail up as well. RPN #104 advised that the staff had been notified earlier that day that they were not to be putting the second rail up. After speaking with RPN #104, Inspector #641 observed resident #001 lying in bed with both ¾ rails in the up position.

The licensee failed to ensure that resident #001 had an order for the restraint by a physical device, such as the two three quarter rails. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraining of resident #001 has been consented to by the resident or substitute decision maker.

Inspector #641 reviewed the resident's health care record. There was no evidence of documentation of consent for the two ¾ bed rails from the resident's substitute decision maker (SDM). There was a restraint consent form in the resident 's chart from the time of admission, with a line through it and a statement indicating that the resident didn't require any restraints at the time of admission.

During an interview with Inspector #641 on August 14, 2018 at 1400, RPN #104 indicated that there was no SDM consent for resident #001 to use two bed rails. The RPN advised that the resident was to only use one full rail. RPN #104 advised that the staff had been notified earlier that day that they were not to be putting the second rail up. After speaking with RPN #104, Inspector #641 observed resident #001 lying in bed with both rails in the up position.

The licensee failed to ensure that the two ¾ bed rail restraint had been consented to by resident #001's substitute decision maker. [s. 31. (2) 5.]

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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care and to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining and 5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent., to be implemented voluntarily, to be implemented voluntarily.

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.