Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2020	2020_617148_0013	005220-20, 006385-20, 007170-20, 021317-20	Critical Incident System

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 2-6 and 9-10, 2020

The following intakes were completed in this Critical Incident System (CIS) inspection: Log #021317-20, Log #007170-20 and Log 006385-20, related to falls and Log #005220-20, related to an injury to a resident for which the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Director, Director of Resident Care, Associate Directors of Care, Registered Nurses, Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed resident care and staff interactions and the residents care environment. In addition, the inspector reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the pain of a resident was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident vocalized pain and showed physical signs of pain. An RPN provided the resident with interventions to help relieve the pain. Five hours later, an RPN described the resident as having pain and provided interventions. Those interventions were described as not effective.

The next day, RPN noted the continued pain and the resident's changes in physical status; the intervention was to monitor.

The pain of the resident was not relieved by initial interventions and the resident was not assessed using a clinically appropriate assessment instrument.

Sources: Progress notes and medication administration record for the resident and interviews with RPNs. [s. 52. (2)]

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 ensure that when the pain of a resident is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was dressed appropriately and in appropriate footwear.

A resident had been dressed in night clothes and regular socks and was placed in bed. The resident later left the bed at which time the resident had a fall, whereby injury was sustained. Residents are to be dressed in gripper socks or bare feet. In this way, the resident was not provided with appropriate dressing.

Sources: Progress notes of the resident and interview with an RPN. [s. 40.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

An RPN provided a resident with the incorrect medication.

Sources: A medication administration record and progress notes for the resident and interview with an RPN [s. 131. (2)]

Issued on this 19th day of November, 2020

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

Original report signed by the inspector.