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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2015	2015_295556_0001	O-001462-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LANARK
P.O. Box 37 Sunset Blvd. PERTH ON K7H 3E2

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

WENDY PATTERSON (556)

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): January 5, 6, 7, and 8, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DOC), Associate Director of Care (ADOC), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Recreation Worker.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in Resident #001's plan of care was provided to the resident as specified in the plan.

During the course of a critical incident inspection Inspector #556 reviewed Resident #001's health care record and noted that the care plan under the focus of Psychosocial Well Being states that staff are to explain procedures to Resident #001 before beginning them, that Resident #001 will tell staff to "go away" or "you may go now", when this is said it is important to leave, not persevere with the task as resident will not be agreeable and may become agitated. Re-approach later. Under the focus of Behaviour the care plan states if resident is increasingly agitated it is best just to leave him/her alone, ensuring he/she is safe, and return some time later.

The progress notes from December 16 & 17, 2014 indicated that Resident #001 was hitting/pinching staff at bedtime on December 16, 2014 when they were attempting to change the resident into pajamas and settle him/her into bed. During the incident staff were holding Resident #001's wrists and #001 sustained a skin tear to both right and left wrist.

In an interview the Associate Director of Care stated that when she spoke with PSW #101 regarding the incident PSW #101 told her that she restrained Resident #001's wrists while attempting to undress him/her, she said she knew she shouldn't have held #001's wrists, she should have walked away.

In an interview PSW #104, who works regularly with Resident #001 stated that Resident #001 has responsive behaviours that are mostly well controlled but get worse in the evening. Stated that it is not acceptable to force Resident #001 to receive care, the expectation is that staff are to re-approach the resident at a later time if care is being refused. PSW #104 further stated that sometimes #001 is left to be put to bed on the night shift if the evening shift were not successful. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect Resident #001 from abuse by staff member #101.

During the course of a critical incident inspection regarding an incident that occurred on on a specific date Inspector #556 reviewed the critical incident report which was submitted to the MOHLTC by the LTC home. The report stated that on while PSW #101 and PSW #102 were attempting to provide care Resident #001's wrists were restrained by PSW #101 resulting in skin tears to both of the resident's wrists. The critical incident report further stated that during the incident Resident #001 was slapped by staff member #101.

In an interview PSW #102 stated that on the specific date while attempting to provide care to Resident #001 PSW #101 held the resident's wrists too forcefully which made her very uncomfortable because she didn't think it was necessary to force #001 to put his/her pajamas on. She further stated that she also witnessed PSW #101 slap Resident #001. PSW #102 stated that she perceived the action of PSW #101 to be physical abuse of Resident #001.

In an interview RPN #103 stated that she was on duty when the incident occurred however she was not in Resident #001's room. She explained that PSW #102 called her to come and assess the skin tears on #001's wrists so they could be treated and dressings applied. RPN #103 stated that there were skin tears present on both of the resident's forearms.

In an interview the Director of Resident Care stated that PSW #101 is no longer employed by the home. She further stated that the slapping and/or the restraining of Resident #001's wrists to force him/her to accept care is considered by the home to be physical abuse. [s. 19. (1)]

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Issued on this 6th day of February, 2015

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

Original report signed by the inspector.