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

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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
Jun 17, 2015	2015_362138_0015	O-002111-15	Resident Quality Inspection

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), RENA BOWEN (549), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 1, 2, 3, 4, 5, 8, 9, 10, 11, and 12, 2015.

Concurrent Critical Incident Inspections completed:
O-000335-14
O-000638-14
O-000653-14
O-001298-14
O-001299-14
O-001398-14
O-001807-15
O-001930-15
O-002202-15

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, the Chair of the Family and Friends Council, the Chair of the Residents' Council, the home's Director of Long Term Care, the Office Manager, the Director of Care (DOC), the first floor Associate Director of Care (ADOC), the second floor Associate Director of Care (ADOC), Registered Practical Nurses (RPNs), Personal Supports Workers (PSWs), Registered Nurses (RNs), the Registered Dietitian/Associate Food Service Worker, Food Service Workers, the Environmental Services Manager, Maintenance Staff, Laundry Aides, Housekeeping Aides, a Recreation Aide, and the Kinesiologist.

The inspectors also toured residential and non residential areas (including medication rooms), reviewed several Critical Incident Reports, reviewed several resident health care records, observed meal services, observed a medication pass, reviewed several of the home's policies and procedures relating to abuse, lift policy, and fall prevention and management, and reviewed internal investigation documentation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **1 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 O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

On June 1, 2015, Inspector #573 observed that the home elevators in the (A) wing and (C) wing located inside the building services the first floor and second floors which are resident home areas, as well as the lower level. It was noted by Inspector #573 that both the elevators on all the floors have an up and down arrow button panel outside the elevators with a clear plexiglas acrylic sheet cover over the button panel. It was noted that those plexiglas acrylic sheet covers have two holes which can slide up and down to access those elevator buttons. The inspector was able to call each elevator by sliding the plexiglas cover and selecting the up or down button. Once inside either elevator the inspector was able to access all floors in the building including the lower level. The inspector proceeded to the lower level from both elevators and observed multiple corridors, some which are used to store furniture and equipment, and other corridors that lead to rooms such as a staff office, staff lounge, a resident hair salon, the kitchen, the laundry room, the garbage room, the elevator mechanical room, a boiler room, a maintenance storage room, and an electrical room. At the time of tour of the lower level, the inspector noted that the doors to the boiler room, maintenance storage room, and the electrical room were propped open. The inspector did not observe any staff members in those rooms or nearby vicinity to provide supervision should a resident wander into the area from the elevators.

On June 1, 2015, Inspector #573 spoke with the home's Director of Long Term Care regarding elevator access to the lower level. The home's Director of Long Term Care indicated that the lower level of the home is not to be accessed by any residents except for the purpose of the resident hair salon and further stated that all residents going to the hair salon in the lower level are to be supervised by staff.

On June 4, 2015, Inspector #573 was reviewing Resident #025's health care record and noted a progress note dated June 1, 2015 which stated that Resident #025 had activated the elevator for a cognitively impaired resident. The other resident had used the elevator to travel unsupervised to the lower level.

On June 4, 2015, Inspector #573 again spoke with the home's Director of Long Term Care who agreed that the elevator is required to restrict resident access to the lower level and that arrangements have been made to install a system within the elevators to restrict resident access to the lower level.

The lack of a system to restrict resident access from both elevator to the lower level of the home presents a potential risk to residents, particularly those who may exhibit wandering or exit seeking behaviours. [s. 10. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 license failed to comply with section 5. of the Act in that the licensee failed to ensure the home is a safe and secure environment.

During the course of the inspection, it was noted by several inspectors that the coffee dispenser in the Glen View dining room and the coffee/tea/hot water dispenser in the Blue Skies dining room were turned on and were accessible to residents without supervision. The inspector spoke with several food services workers on June 10 and 11, 2015 who told Inspector #138 that both hot beverage dispensers were left on 24 hours a day. The food service workers stated that the hot beverages and the hot water that comes from these hot beverage dispensers would be hot, consistent with any hot beverage. The inspector noted that the hot beverages poured from both hot beverage dispensers were hot and steamy. The inspector spoke with the Associate Food Service Supervisor on June 9, 2015, who stated that the hot beverage dispensers were accessible to residents although only one resident was known to access the hot beverage dispenser in the Glen View dining room. The Associate Food Service Supervisor also stated that these hot beverage dispensers did not have a safety mechanism in place to prevent unsupervised resident access and she also recognized an increased demographic of residents with impaired cognitive abilities attending the Glen View dining room. [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 reduce potential resident risk of injury from the accessibility of the hot beverage machines while still allowing accessibility of hot beverages to residents where appropriate, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

During the course of the inspection, Critical Incident Report #M548-000013-14 was reviewed and indicated that on a day in June 2014 a PSW was transporting Resident #032 in a wheelchair without using foot pedals resulting in a fracture.

A review of Resident #032's health care record indicated that the resident has a diagnosis of Alzheimer's disease with short and long term memory problems and that the resident's cognitive skills for daily decision making are impaired.

The progress notes documented in June 2014 were reviewed and do not indicate that Resident #032's SDM was notified of the resident's injury. Internal investigation

documentation provided by the home's Director of Long Term Care indicated that the day after the incident the SDM called the home's Director of Long Term Care asking what had happened to cause the injury to Resident #032; and an email communication dated five days after the incident from the SDM to the home's Director of Long Term Care stated s/he had not been contacted regarding Resident #032's condition, nor had s/he been advised that pain medication had been prescribed for Resident #032.

In an interview, the home's Director of Long Term Care stated that it is the expectation that the SDM is notified by the registered nursing staff when there is a change in a resident's condition.
(Log #O-000638-14) [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the course of the inspection, Critical Incident Report #M548-000024-14 was reviewed and it was noted that Resident #044 sustained a fall and has a history of multiple falls.

Resident #044's current plan of care was revised in June 2015. The resident was assessed as being at a high risk for falls. The plan of care indicated that one of the fall prevention interventions for Resident #044 was to ensure that the call bell is within reach at all times.

On June 8, 2015 at 12:30 pm and June 9, 2015 at 10:00 am Resident #044 was observed by Inspector #549 to be in bed with the right side rail in the up position and the fall mat on the floor on the left side of the bed as per the plan of care. However, the call bell was on the floor at the head of the bed on the right side out of the residents reach during both observations. The planned care was not provided to the resident as specified in the plan.

June 9, 2015, during an interview with RPN #103 it was indicated to Inspector #549 that the resident may not be capable to use the call bell but was unsure. The RPN also stated that it was unlikely that the resident would put the call bell on the floor out of reach as observed by the inspector on June 8 and 9, 2015.

The DOC confirmed during an interview with Inspector #549 on June 9, 2014 that the resident's plan of care states that the call bell is to be within reach for Resident #044 at

all times. The DOC also indicated that the expectation is that the call bell be within reach for the resident at all times.

On June 10, 2015 at 2:00 pm and June 11, 2015 at 10:00 am, Inspector #549 observed Resident #044 in bed with the call bell pinned to the pillow case for easy access. (Log # O-001299-14) [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care for Resident #048 in relation to responsive behaviours was not provided to the resident as specified in the plan.

Critical Incident Report #M548-000014-14 was submitted to the Director in July 2014 for an incident of resident to resident physical abuse resulting in injury that occurred that day. The Critical Incident Report indicated Resident #048 was in the dining room and began hitting Resident #049, causing Resident #049 to bleed. The Critical Incident Report also indicated that Resident #048 was very aggressive and resistive to morning care, which has been delivered by a PSW staff less than one hour prior to occurrence of the incident. The Critical Incident Report indicates that the PSW staff failed to communicate Resident #048's aggressive and resistive behaviour to the RPN who may have been able to prevent the incident as the resident may have been assessed to remain outside the dining room due to behaviours.

On June 9, 2015, Inspector #573 reviewed the resident's health care record and noted several progress notes outlining physical aggression. The inspector also reviewed the plan of care in effect at the time of the incident for Resident #048's responsive behaviours and noted several interventions for physical aggression.

On June 8, 2015, the inspector spoke with ADOC #108 who indicated that staff members should not bring resident #048 to the dining room to sit with other residents when Resident #048 exhibits resistive and aggressive behaviours. The ADOC #108 also indicated that staff were not following the interventions for responsive behaviours as specified in the plan of care for Resident #048 when the incident in July 2015 occurred. (Log# O-000653-14). [s. 6. (7)]

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 all staff who provide direct care to Resident #048 follow the resident's plan of care for responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to comply with section 13 of the regulation whereby every resident bedroom occupied by more than one resident did not have sufficient privacy curtains to provide privacy.

It was noted by Inspector #138 on June 4, 2015, that the following second floor shared rooms/beds did not have sufficient privacy curtains to ensure privacy:

1) 203A, 203B, 202A, 202B, 206A, 206B, 213A, 216A, 223A, and 223B - the privacy curtains in these rooms were prevented from fully closing, leaving an opening of approximately three feet, related to the placement of the ceiling lift track.

2) 217A, 217B, 220A, and 220B - the privacy curtains in these rooms only provided partial privacy as the track for the privacy curtains did not take into account the multi-level drop ceiling.

Resident #004, who resides in one of the shared rooms identified above, expressed to the inspector that it would be desirable to have the privacy curtains fully close.

This issue had also been identified in the last RQI that occurred in January 2014. [s. 13.]

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 all shared resident rooms have sufficient curtains to provide privacy, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

During the course of an inspection Critical Incident Report #M548-000013-14 was reviewed and indicated that on a day in June 2014 a PSW was mobilizing Resident #032 in a wheelchair without foot pedals in place. During the transportation the resident put his/her feet down to the floor and the resident's leg got caught and twisted under the chair. At the time of the incident the resident experienced pain, and continued to complain of pain afterward. The resident was sent to the hospital and was diagnosed with a fracture.

In an interview ADOC #101 stated that the PSW involved did not report the incident, it was the Physiotherapy Assistant who discovered that Resident #032 had been injured. ADOC #101 further stated that an investigation was initiated and it was discovered that a PSW had been transporting Resident #032 in a wheelchair without attaching the foot pedals resulting in a fracture. ADOC #101 further stated that it is against the home's policy to transport a resident in a wheelchair without the foot pedals in place, and as a result the PSW received discipline, and all staff were reminded of the policy.

The Nursing Administration Policy #G-40.40(a) entitled Transferring a Resident Protocol with a revision date of March 2014 was reviewed and stated "ensure that foot pedals are in place when transporting a resident in their wheelchair."

(Log #O-000638-14) [s. 36.]

2. During the course of the inspection Critical Incident Report #M548-000006-14 was reviewed and noted to indicate a fall for Resident #052 on a day in April 2014 when the resident was being repositioned by PSW #110. On June 11, 2015, PSW #110 stated to Inspector #138 that Resident #052 was ill on the day in April 2014, that the resident had received an in-room tray for supper, and that the PSW had transported the resident after the meal to the lounge area for increased monitoring by staff. PSW #110 stated that she transported the resident via the resident's own transport wheelchair from the resident's room to the lounge where she then attempted to make the resident more comfortable by elevating the resident's feet while the resident was seated in the transport chair. In doing so, the wheelchair tipped back and the resident sustained a fall. No injuries were noted related to the fall however the resident was transferred to the hospital for assessment relating to general poor health. PSW #110 stated to the inspector that Resident #052 normally ambulated around the unit with a four wheeled walker and only used the transport wheelchair for long distances.

The inspector spoke with the home's Kinesiologist regarding the incident. The Kinesiologist #109 stated that Resident #052 used a foldable transport wheelchair and that these types of chairs are only meant for transporting a resident but not for sitting as there is no anti-tip mechanism. The Kinesiologist stated that residents should be transferred from a transport wheelchair to a proper chair once the resident has been transported.

Resident #052 was not transferred to a proper chair once transported to the lounge and the resident was attempted to be positioned in a manner that resulted in a fall.
(Log# O-000335-14) [s. 36.]

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 staff use safe transferring and positioning devices and techniques when assisting residents with wheelchairs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Related to Log # O-001298-14

Critical Incident Report #M548-000023-14 indicated that Resident #043 had an unwitnessed fall in November 2014. The resident was transferred to hospital that day and returned to the home later that evening with interventions in place. The Licensee informed the Director through the Critical Incident Reporting System two business days after the Licensee became aware of the significant change in the resident's health status.

Related to Log # O-001299-14

Critical Incident Report #M548-000024-14 indicated that Resident #044 had an unwitnessed fall in November 2014. The resident was transferred to hospital the same day and returned to the home later in the evening with a diagnosis of a fracture and a large hematoma. The Licensee informed the Director through the Critical Incident Reporting System two business days after the Licensee became aware of the significant change in the resident's health status.

Related to Log # O-001807-15

Critical Incident Report #M548-000009-15 indicated that Resident #042 began complaining of pain on a day in March 2015. The resident stated that s/he had fallen off the toilet. Resident #042 was transferred to hospital that same day for assessment of pain. The following day the home was informed by the Perth Hospital emergency department that Resident #042 had sustained a fracture that would require surgical intervention. The Licensee informed the Director using the Critical Incident Reporting System three business days after the Licensee became aware of the significant change in the resident's health status.

Related to Log # O-002147-15

Critical Incident Report #M548-000018-15 indicated that on a day in May 2015 Resident #047 reported that s/he was in the bathroom a "few days ago" and felt himself/herself go over on his/her right ankle and has had trouble walking since. Later that same day Resident #047 stated s/he could not weight bear. The following day Resident #047 was transferred to hospital for assessment. The resident returned to the home that same day with a diagnosis of a fracture. The Licensee informed the Director using the Critical Incident Reporting System six business days after the Licensee became aware of the significant change in the resident's health status.

Related to Log# O-002202-15

Critical Incident Report #M548-000020-15 indicated that Resident #041 had an unwitnessed fall on a day in May 2015. That same day staff noted bruising on the resident and the resident was transferred to hospital for assessment. The resident returned to the home the same day with a diagnosis of a fracture. The Licensee informed the Director using the Critical Incident Reporting System nine business days after the Licensee became aware of the significant change in the resident's health status.

On June 9, 2015 during an interview the DOC and ADOC #108 indicated to Inspector #549 that they were unaware that the Licensee is required to inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition. [s. 107. (3)]

2. Related to Log #O-000638-14

During the course of an inspection Critical Incident Report #M548-000013-14 was reviewed and indicated that on a day in June 2014 a PSW was transporting Resident #032 in a wheelchair without using foot pedals resulting in a fracture. The Critical Incident Report was submitted to the Ministry of Health and Long Term Care three days later.

In an interview Kinesiologist #109 stated that prior to the incident Resident #032 was able to walk with a 4 wheel walker and 2 people assisting, however since the incident Resident #032 has not been able to weight bear and has required a mechanical lift with 2 people assisting to transfer.

In an interview the DOC stated that they began working on the Critical Incident Report at the time of the incident but did not submit it until three days later.
(Log #O-000638-14) [s. 107. (3) 4.]

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 Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home are kept locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm. This is specifically related to the home's double doors known as the ambulance entrance/exit door.

On June 1, 2015, Inspector #573 noted that the home's ambulance entrance/exit door from the west parking lot was not locked. The inspector was able to open one of the ambulance entrance/exit doors from both inside and outside of the home. It was also observed by the inspector that the same door was not equipped with an alarm. This was immediately reported to the home's Director of Long Term Care.

On June 1, 2015 at approximately 2:15 pm, Inspector #573 observed the home's ambulance entrance/exit door in the presence of the home's Director of Long Term Care who concurred with the inspector that one of these doors was not locked nor alarmed. Further, the home's Director of Long Term Care indicated that she will notify maintenance staff to lock and alarm the ambulance entrance/exit doors immediately.

On June 5, 2015, in the presence of home's Director of Long Term Care and the Environmental Service Manager, the inspector verified that the home's ambulance entrance/exit doors were locked and alarmed. [s. 9. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. In accordance with section 110.(7)3. of the regulation and section 31.(2)4. of the Act, the licensee failed to ensure that every use of a physical device to restrain a resident is documented including the person who made the order, what device was ordered, and any instructions relating to the order.

In an interview, RPN #104 and PSW #105 indicated that Resident #033 uses 4 raised half rails as a restraint when in bed and that the bedrails prevent the resident from voluntarily exiting the bed.

A review of MDS data submitted in April 2015 indicated under Section P #4 Devices and Restraints, that full bedrails on all open sides of Resident #033's bed were used daily.

A review of Point of Care Task documentation for a 14 day period between the dates May 25, 2015 to June 8, 2015 under the category of restraint use indicated that "4 Half Siderails (All 4 rails up)" were used for Resident #033 14 out of 14 days.

In an interview RPN #106, who was working on the unit where Resident #033 resides, stated that there is to be a Physician's order for any restraint used in the home. RPN #106 reviewed the Resident's health care record and was not able to locate a Physician's order for the bedrail restraint. [s. 110. (7) 3.]

2. In accordance with section 110.(7)4. of the regulation and section 31.(2)5. of the Act, the licensee failed to ensure that every use of a physical device to restrain a resident is documented including consent by the resident's SDM.

A review of Resident #033's health care record indicated that the resident has a diagnosis of Alzheimer's disease with short and long term memory problems and that the Resident's cognitive skills for daily decision making are severely impaired.

In an interview RPN #104 and PSW #105 stated that Resident #033 uses 4 raised half rails when in bed and that the bedrails prevent the resident from voluntarily exiting the bed.

RPN #106, who was working in the unit where Resident #033 resides reviewed the Resident's health care record and was not able to locate consent for the bedrail restraint [s. 110. (7) 4.]

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

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Issued on this 17th day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), RENA BOWEN (549), WENDY PATTERSON (556)
Inspection No. / No de l'inspection :	2015_362138_0015
Log No. / Registre no:	O-002111-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 17, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF LANARK P.O. Box 37, Sunset Blvd., PERTH, ON, K7H-3E2
LTC Home / Foyer de SLD :	LANARK LODGE 115 Christie Lake Road, R. R. #4, Lot 27, Concession 2, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEB PIDGEON

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To THE CORPORATION OF THE COUNTY OF LANARK, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee is required to ensure that the home's two elevators in (A) and (C) wings are equipped to restrict resident access to the lower level of the home. While the licensee is addressing elevator access, the licensee must immediately mitigate any risks relating to the accessibility of residents unsupervised on the lower level of the home.

Grounds / Motifs :

1. The licensee failed to ensure that the elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

On June 1, 2015, Inspector #573 observed that the home elevators in the (A) wing and (C) wing located inside the building services the first floor and second floors which are resident home areas, as well as the lower level. It was noted by Inspector #573 that both the elevators on all the floors have an up and down arrow button panel outside the elevators with a clear plexiglas acrylic sheet cover over the button panel. It was noted that those plexiglas acrylic sheet covers have two holes which can slide up and down to access those elevator buttons. The inspector was able to call each elevator by sliding the plexiglas cover and selecting the up or down button. Once inside either elevator the inspector was able to access all floors in the building including the lower level. The inspector proceeded to the lower level from both elevators and observed multiple corridors, some which are used to store furniture and equipment, and other corridors that lead to rooms such as a staff office, staff lounge, a resident hair salon, the kitchen, the laundry room, the garbage room, the elevator mechanical room, a boiler room, a maintenance storage room, and an electrical room. At the time of tour of the lower level, the inspector noted that the doors to the boiler room, maintenance storage room, and the electrical room were

propped open. The inspector did not observe any staff members in those rooms or nearby vicinity to provide supervision should a resident wander into the area from the elevators.

On June 1, 2015, Inspector #573 spoke with the home's Director of Long Term Care regarding elevator access to the lower level. The home's Director of Long Term Care indicated that the lower level of the home is not to be accessed by any residents except for the purpose of the resident hair salon and further stated that all residents going to the hair salon in the lower level are to be supervised by staff.

On June 4, 2015, Inspector #573 was reviewing Resident #025's health care record and noted a progress note dated June 1, 2015 which stated that Resident #025 had activated the elevator for a cognitively impaired resident. The other resident had used the elevator to travel unsupervised to the lower level.

On June 4, 2015, Inspector #573 again spoke with the home's Director of Long Term Care who agreed that the elevator is required to restrict resident access to the lower level and that arrangements have been made to install a system within the elevators to restrict resident access to the lower level.

The lack of a system to restrict resident access from both elevator to the lower level of the home presents a potential risk to residents, particularly those who may exhibit wandering or exit seeking behaviours. (573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

Service Area Office /
Bureau régional de services : Ottawa Service Area Office