



**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  
Direction de l'amélioration de la  
performance et de la conformité**

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 public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 31, 2015	2015_450138_0006	O-002346-15	Critical Incident System

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### **Licensee/Titulaire de permis**

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

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### **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

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

PAULA MACDONALD (138)

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## **Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): July 29, 2015.**

**During the course of the inspection, the inspector(s) spoke with the Director of Resident Care.**

**The inspector also reviewed a Critical Incident Report and several internal documents related to this Critical Incident Report.**

**The following Inspection Protocols were used during this inspection:  
Critical Incident Response**

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

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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).**

#### **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.

In June 2015, a resident had an unwitnessed fall and was transferred to the hospital. The resident was diagnosed with a fracture and returned to the home later that same day. The home attempted to inform the Director of this incident the same day, however, the home did not follow notification procedures set out by the Director. The Director, therefore, was not made aware of the incident until eleven days later when the Director of Resident Care submitted a Critical Incident Report through the electronic Critical Incident System. [s. 107. (3)]



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**Issued on this 31st day of July, 2015**

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

**Original report signed by the inspector.**