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 24, 2017	2017_505103_0045	023099-17	Complaint

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 12-13, 2017

023099-17 (complaint related to resident care).

During the course of the inspection, the inspector(s) spoke with Personal support workers (PSW), a Registered Practical Nurse, a Registered Nurse (RN) and the Administrator.

During the course of the inspection, the inspector reviewed a resident health care record and made resident observations.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure different approaches were considered with resident #001, when the care set out in the plan of care had not been effective.

Resident #001 was admitted to the home on a designated date and had identified diagnoses. On an identified date on or about 0600 hour, resident #001 received an injury while staff were assisting the resident to get dressed.

PSW #101 was interviewed and stated she was one of the PSW's that was assigned to resident #001 on the identified date. She stated she was familiar with this resident's care needs and had cared for this resident before. The PSW stated the resident was lying on their back in bed while she and PSW #106 attempted to dress the resident. The PSW stated the resident was kicking their legs, but could not recall if the resident's legs ever made contact with anything that could have caused the injury. She stated she noted some blood and they informed RPN #100 to come and assess the area. PSW #101 stated this resistance to care was not unusual for this resident. She stated that while trying to help the resident get dressed the PSW's were talking with the resident and trying to keep the resident calm, but with no effect.

RPN #100 was interviewed. She stated she was working the night shift when the injury occurred. She stated PSW's #101 and #106 had reported to her that while attempting to assist the resident with getting dressed, the resident was resisting the care by kicking their legs and grabbing onto the clothing. The RPN stated the PSW's reported to her they saw blood and called her to assess the injury at approximately 0600 hour. The RPN stated she dressed the injury and remained in the room while the staff finished getting the resident dressed and into the wheelchair. She stated that throughout that time resident #001 continued to kick their legs and attempted to resist the care being provided.

PSW's #102, #103, and #104 were separately interviewed in regards to different approaches they use to reduce a resident's resistance to care. All stated they would leave the resident and try to reapproach at a later time, try a different staff member or distract with conversation.

PSW's #103 and #104 were both interviewed separately in regards to resident #001's care needs. Both indicated this resident was resistant to care especially during the morning when staff attempt to dress the resident and this behavior was not new. Both of the PSW's stated the current interventions in place to reduce this resistance included

talking with the resident, going slowly and trying to distract the resident using a doll. Both indicated none of these approaches were effective. Additionally, PSWs #103 and #104 stated reapproach or different staff attempting the care had been tried in the past and was not effective in reducing the resistance to care. The PSW staff agreed that once the care was completed, the resident calmed down.

Resident #001's plan of care was reviewed and indicated the following under "Responsive Behaviours ":
-resident has repetitive anxious complaints,
-unpleasant mood in the morning which is not easily altered due to a cognitive impairment.
The interventions indicated:
- place baby doll near resident to provide comfort,
-2 staff to provide all care,
-Distract with conversation
-be careful not to invade resident's personal space,
-be sure you have the resident's attention before speaking or touching the resident.

RN #105 was interviewed about the current interventions being used for resident #001 for resistance to care. The RN stated she was aware of the resident's resistance to care especially while staff provided morning care and that the interventions in place did not seem to be effective. The RN stated she was unaware if additional interventions had been tried to reduce resident #001's resistance.

The inspector found no documented evidence to support alternative approaches had been tried to reduce this resident's resistance to care. [s. 6. (11) (b)]

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 different approaches are considered in the revision of resident #001's care plan to address the resident's resistance to care, to be implemented voluntarily.

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.