Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2019	2019_770178_0015	011411-19, 011517-19, 013846-19, 014252-19	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

SUSAN LUI (178)

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): August 9, 12, 13, 14, 15, 16, 19, 20, 2019.

The following Critical Incident Logs were inspected:
013846-19 (CIR #M548-000032-19) regarding a fall with injury
011411-19 (CIR #M548-000026-19), 011517-19 (CIR #M548-000027-19) and 014252-19 (CIR #M548-000033-19) , all regarding alleged resident to resident abuse.

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

During the course of this inspection, the inspector also reviewed resident health records, reviewed home records, observed residents, resident home areas, and resident care.

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

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provide direct care to resident #001 were kept aware of the contents of the plan of care.

This non-compliance is related to Log #013846-19.

Review of the health record indicated that Resident #001 was at high risk for falls and ambulated using a four wheeled walker. Resident #001 fell on three identified dates. New fall prevention measures were implemented after the first of the three falls and further fall protection measures were implemented two weeks later. After the third fall the resident's plan of care was further revised to indicate that the resident required one person assist and a four wheeled walker to walk within their room, in the corridor and on the unit.

On August 20, 2019, Inspector #178 interviewed PSW #112 who provided care to resident #001, regarding resident #001's fall risk and prevention interventions. PSW #112 indicated that resident #001 walks independently using a four wheeled walker and does not need staff assistance for walking. PSW #112 indicated that staff will assist the resident to sit down if they observe them having difficulty walking, but otherwise the resident walks independently using the walker. PSW #112 was aware of resident #001's other fall prevention measures but was unaware that resident #001's plan of care had been revised to indicate that staff was to assist the resident with walking in their room or on the unit.

As such, the licensee has failed to ensure that staff and others who provide direct care to resident #001 were kept aware of the contents of the plan of care. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the plan of care, to be implemented voluntarily.

Issued on this 27th day of September, 2019

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

Original report signed by the inspector.