Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: November 2, 2022
Inspection Number: 2022-1565-0002
Inspection Type: Complaint Critical Incident System
Licensee: The Corporation of the County of Lanark
Long Term Care Home and City: Lanark Lodge, Perth

Lead Inspector	**Inspector Digital Signature**
Darlene Murphy (103)	Darlene Murphy Digitally signed by Darlene Murphy Date: 2022.11.21 09:01:56 -05'00'

Additional Inspector(s)
Erica McFadyen (740804)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 26-30. October 3-4, 2022.

The following intake(s) were inspected:
- Intake #00001157 [CI: M548-000006-22]-alleged staff to resident neglect,
- Intake #00006386 [CI: M548-000010-22]-resident fall that resulted in an injury,
- Intake #00002023 [Complaint]-related to resident care.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Medication Management
Safe and Secure Home

Food, Nutrition and Hydration

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 12 (1) 3.

Rationale and Summary
On September 26, 2022, during the initial tour of the home, doors leading to five non-residential areas were found to be unlocked. All the doors were equipped with locks that were later identified as defective. The Director of Care (DOC) was informed and advised action would be taken. The door locks were replaced prior to the completion of this inspection.

Date Remedy Implemented: October 3, 2022. [103]

WRITTEN NOTIFICATION: Administration of Drugs

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary
An RPN allegedly failed to administer the prescribed medications at bedtime to the residents. The long-term care home (LTCH) completed an investigation that included a review of the resident medication records, video surveillance and interviews with staff members that worked that evening. Upon completion of the investigation, the LTCH concluded there was sufficient evidence to support the

allegation.

Failure to administer medications as prescribed can result in harm to the residents.

Sources
Interviews with Administrator, DOC and Human Resources, review of the home's investigation notes. [103]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
Staff members working alongside an RPN suspected the residents were not receiving their medications at bedtime but failed to report their concerns to the charge nurse. Two days later, the incident was discovered and reported to the management team who initiated an immediate investigation.

The home's abuse policy indicates all team members are required to immediately report any suspected or known incident of resident abuse or neglect to the designate in charge and failing to do so puts residents at risk of harm.

Sources
Interviews with staff members and DOC, review of the abuse policy. [103]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

A person who had reasonable grounds to suspect resident neglect by a staff member that resulted in harm or risk of harm failed to immediately report the suspicion and information upon which it was based to the Director.

Rationale and Summary
The Director of Care (DOC) became aware of an incident whereby an RPN had allegedly failed to administer medications to the residents. The critical incident (CIS) was submitted for the first time to the Director approximately two weeks later.

Failing to immediately notify the Director of alleged resident neglect places residents at risk of additional harm.

Sources
Critical incident report, and interview with DOC. [103]

WRITTEN NOTIFICATION: Police notification

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 105

The licensee failed to ensure the appropriate police force was immediately notified of an alleged incident of staff to resident neglect.

Rationale and Summary
The Director of Care (DOC) became aware of an incident whereby an RPN had allegedly failed to administer medications to the residents. The police were not notified of this alleged incident of neglect. The DOC and the Administrator indicated this was an oversight.

Failing to immediately notify the police of alleged incidents of neglect places residents at risk of harm.

Sources
Critical incident report, interviews with DOC and Administrator. [103]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure the Director was notified within one business day of an incident that

caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary
A resident sustained a fall and was transferred to the hospital for further assessment. The home became aware the resident had a significant change in their health condition but failed to notify the Director within one business day.

Sources
Review of the resident clinical record, Critical incident report, and interview with Assistant Director of Care (ADOC).
[Inspector ID 740804]

WRITTEN NOTIFICATION: Fall prevention and management

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
A resident sustained two falls within one hour. Review of the clinical documentation indicated that following the resident's first and second fall, their post fall assessments were not completed in full. The RPN and ADOC acknowledged that it is the expectation that all fields of this assessment must be completed.

Not completing a post fall assessment placed the resident at risk of additional falls and injury as the fall prevention measures were not assessed for their effectiveness.

Sources
Review of the clinical record for the resident, interviews with registered staff and the ADOC. [Inspector ID 740804]