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

Ottawa District
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Original Public Report

Report Issue Date: May 8, 2023	
Inspection Number: 2023-1565-0003	
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 Darlene Murphy (103)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-28, 2023 and May 1-3, 2023.

The following intake(s) were inspected:

- Intake: #00012255 (CI: M548-000015-22) and Intake: #00021023 (CI: M548-000008-23)-resident falls that resulted in an injury,
- Intake: #00018060 (CI: M548-000003-23)-complaint forwarded to the Director regarding resident care,
- Intake: #00021226 (CI: M548-000011-23)-alleged incident of improper/incompetent treatment of residents by a staff member,
- Intake: #00084856 (CI: M548-000018-23)-alleged incident of resident to resident abuse,
- Intake: #00012144 and Intake: #00022872 -complaints related to resident care.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

A person who had reasonable grounds to suspect improper or incompetent care of a resident failed to immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary:

A Registered Nurse (RN) suspected a Registered Practical Nurse (RPN) was unfit to continue working. The RN notified the on-call manager and the RPN was removed from direct resident care. The home immediately began their investigation to determine any impact on the residents.

The Administrator stated the Director was notified for the first time by means of a Critical incident (CI) that was submitted the following day. The Administrator indicated the failure to contact the after-hours pager immediately was an oversight as the focus was on ensuring all the residents received appropriate and safe care.

Sources: CI M548-000011-23, interview with RN and Administrator.

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