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**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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| **Report Issue Date: August 24, 2023.** | |
| **Inspection Number:** 2023-1565-0005 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** The Corporation of the County of Lanark | |
| **Long Term Care Home and City:** Lanark Lodge, Perth | |
| **Lead Inspector**<br>Heath Heffernan (622) | **Inspector Digital Signature**<br>Heath Heffernan Digitally signed by Heath Heffernan Date: 2023.08.24 11:08:44 -04'00' |
| **Additional Inspector(s)**<br>Anna Earle (740789) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 3, 4, 8-11, 15-17, 2023

The following intake(s) were inspected:
• Critical Incident Intake: #00090659/CI: M548-000034-23 and #00091408/CI: M548-000038-23 - related to alleged staff to resident abuse.
• Critical Incident Intake: #00093177/CI: M548-000042-23 - related to alleged neglect of a resident.
• Critical Incident Intake: #00090898/CI: M548-000035-23, #00091351/CI: M548-000037-23 and #00093332/CI: M548-000043-23 - related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.
• Critical Incident Intake: #00092752/CI: M548-000041-23 and #00093635/CI: M548-000046-23 - related to complaints to the licensee (resident care and services).

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

**i)** The licensee has failed to ensure that the care set out in the falls plan of care was provided to a resident as specified in the plan.

**Rationale and Summary**
During the inspection, Inspector #622 observed a resident was not wearing specific fall prevention equipment.

A review of the plan of care indicated that the resident was to wear specified fall prevention equipment.

During an interview with Inspector #622, a Personal Support Worker (PSW) stated that they had not applied the resident's specified fall prevention equipment as directed in the plan of care.

By not following the resident's fall prevention plan of care, increases the risk of falling and injury for the resident.

**Sources:** review of the plan of care including the care plan document and interview of a PSW and other staff.
[622]

**ii)** The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary**
Critical Incident System report (CI) #M548-000042-23, indicated that on a date in July 2023, during rounds, the night staff observed that a resident remained up during rounds.

The plan of care indicated that the resident had a specified bedtime that was earlier in the evening.

During an interview with Inspector #622, a Personal Support Worker (PSW) stated that on the date in July 2023, the resident remained up approximately two hours after the resident's preferred bedtime.

By not following the resident's plan of care related to bedtime preferences impacts the resident's rights and wishes.

**Sources:** review of (CI) #M548-000042-23, the plan of care including the care plan and interview with a PSW and other staff.
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## WRITTEN NOTIFICATION: Licensee must investigate, respond and act

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

**Rationale and Summary**
Critical Incident System report (CI) #M548-000034-23, was related to an allegation of Personal Support Worker (PSW) to resident abuse on a date in June 2023.

An email dated for the date in June 2023, that was sent by a Registered Practical Nurse (RPN) to the Associate Director of Care (ADOC), described an incident of alleged abuse by a PSW to a resident that caused the resident to become emotional. The email indicated that the RPN had reported a brief description of the incident to the Registered Nurse (RN) in charge however, had not provided further details prior to the end of the RN's shift.

A review of the dates on the licensee's investigation documentation indicated that the ADOC began the investigation the day following the incident of alleged abuse between the PSW and resident.

During an interview with Inspector #622, the RN stated that in the event of an incident of alleged abuse, the RN in charge would start the investigation immediately. On the date in June 2023, the RPN had reported a brief description of the incident that occurred between the PSW and a resident. The RN did

not request clarification from the RPN or investigate the incident that date.

During an interview with Inspector #622, the ADOC indicated that the investigation started the day after the incident of abuse was alleged to have occurred between the PSW and a resident.

By not immediately investigating alleged incidents of abuse, the licensee's ability to make informed decisions related to next steps required to safeguard the residents and reporting may be delayed.

**Sources:** the licensee's investigation documents, interview with the RN and other staff.
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## WRITTEN NOTIFICATION: Reporting certain matters to Director

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that Registered Practical Nurse (RPN) who had reasonable grounds to suspect that verbal abuse to a resident by a Personal Support Worker (PSW) had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

**Rationale and Summary**
According to the licensee's investigation documentation, a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) witnessed an incident of suspected verbal abuse between a PSW and a resident on a date in June 2023. The RPN reported the incident to the RN however, failed to elaborate on the details. Later that shift, the RPN forwarded an email to the Associate Director of Care (ADOC) supplying details of the incident however, the Ministry of Long-Term Care (MLTC) after hours pager was not immediately notified.

The Critical Incident System report (CI) #M548-000034-23, related to the alleged incident of verbal abuse to a resident by a PSW on a date in June 2023, was submitted to the Director of the MLTC the day after the incident occurred.

**Sources:** Critical Incident System report (CI) #M548-000034-23, the licensee's investigation documents.
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