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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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: November 29, 2023
Inspection Number: 2023-1565-0006
Inspection Type: Complaint Critical Incident
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: 2023.11.29 15:39:26 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20- 24, 27-28, 2023.

The following intake(s) were inspected:

- Intake: #00094547 (M548-000047-23), Intake: #00095630 (M548-000049-23), Intake: #00097946 (M548-000054-23), Intake: #00099582 (M548-000061-23)- allegations of staff to resident abuse/neglect,
- Intake: #00098828- (M548-000056-23) and #00100686-(M548-000063-23) - resident falls that resulted in injuries,
- Intake: #00097857 -Complaint related to resident care.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure care was provided to residents as specified in the resident plan of care.

Rationale and Summary:

A resident attempted to call for staff assistance after being prepared for bed but did not have access to their call bell. Staff failed to complete any additional checks on the resident for the remainder of that evening and throughout the night shift. The day staff found the resident upset as they had been incontinent as a result of being unable to call for staff assistance. The resident's plan of care indicated staff were

required to complete hourly rounds.

During another incident, a resident was found seated in their wheelchair in the resident lounge by night staff while completing their initial rounds. The home investigated and determined the PSW had prepared the resident for bed, placed them in the lounge area and had not completed any additional rounds on the resident prior to the end of their shift. The resident's plan of care was reviewed and indicated the resident's preferred bedtime was 2000 hours and the resident required hourly rounds for the purpose of fall prevention.

Sources: Critical incident reports, home's investigation notes and interviews with Administrator.
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WRITTEN NOTIFICATION: Communication and Response System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure the resident-staff communication and response system was easily seen and accessible to a resident at all times.

Rationale and Summary:

After being prepared for bed by staff members, a resident attempted to call for staff assistance but did not have access to their call bell. The resident was incontinent as a result of being unable to call for staff assistance.

Sources: Critical incident report, review of home's investigation and interview with Administrator.
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