

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

Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1565-0002

Inspection Type:

Complaint

Critical Incident

Licensee: The Corporation of the County of Lanark

Long Term Care Home and City: Lanark Lodge, Perth

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 3, 4, 5, 6, 10, 2025

The following intake(s) were inspected:

Intake: #00138870 - CI: M548-000002-25 - related to Infection, Prevention and Control (IPAC) Intake: #00140200 - complainant concerns related to personal care and resident's weight. Intake: #00140525 - CI: M548-000009-25 and #00140599 - CI: M548-000010-25 related to an allegation of sexually inappropriate behaviours of a resident to another resident.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services Food, Nutrition and Hydration Infection Prevention and Control Prevention of Abuse and Neglect



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Responsive Behaviours Pain 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 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a written plan of care for a specific resident related to health ailment sets out clear directions to staff and others who provide direct care to the resident for pharmacological and non-pharmacological interventions.

Sources: resident's clinical records, interview with Registered Practical Nurse (RPN) and Director of Care (DOC)

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the



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information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of alleged sexual abuse towards a resident by another specific resident was immediately reported to the Director.

Sources: resident's health care records and interview with Director of Care (DOC)

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(e) a weight monitoring system to measure and record with respect to each resident,(i) weight on admission and monthly thereafter, and

The licensee failed to ensure that the resident's weight was measured and recorded monthly between a couple of months.

Sources: resident's clinical records, interview with Registered Dietician (RD) and Director of Care (DOC)