Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 5, 6, 7, 22, 2012	2012_044161_0025	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LANARK
P.O. Box 37, Sunset Blvd., PERTH, ON, K7H-3E2

Long-Term Care Home/Foyer de soins de longue durée

LANARK LODGE
115 Christie Lake Road, R. R. #4, Lot 27, Concession 2, PERTH, ON, K7H-3C6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Lanark Lodge and the Director of Care.

During the course of the inspection, the inspector(s) reviewed Resident # 001's health record and the home's Policy # E-10.00 "Abuse or Suspected Abuse of a Resident."

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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 information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 24 (1) (2) in that, although the licensee had reasonable grounds to suspect that physical abuse of Resident # 001 had occurred, the licensee failed to immediately report the suspicion and the information upon which it was based to the Director.

In November 2011 Personal Support Worker # S103 observed Personal Support Worker # S104 roughly grab Resident # 001's left wrist and hand to remove it from a handrail located in the corridor near the resident's room. This resulted in physical injury of Resident # 001's left wrist.

Four days later in November 2011, Personal Support Worker # S103 informed the Director of the Home of the incident that occurred involving Personal Support Worker # S104 and Resident # 001. The Director of the Home conducted an immediate investigation into the allegation which resulted in disciplinary action of Personal Support Worker # S104.

Eleven days later in November 2011 after the Director of the Home initiated an immediate inspection into the allegation, the Director was informed via the Critical Incident System of the alleged staff to resident physical abuse.

Issued on this 22nd day of June, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs