Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 23, 2013	2013_184124_0005	O-000109-13	Complaint

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 16-18 and 23, 2013.

During the course of the inspection, the inspector(s) spoke with the Resident, Director of Long Term Care/Administrator, Director of Care, Associate Director of Care, one Registered Nurse, three Registered Practical Nurses, six Personal Support Workers and the physician.

During the course of the inspection, the inspector(s) reviewed the resident's health record, observed resident dining and staff-resident interactions.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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1. The licensee failed to comply with the LTCHA 2007, s. 6. (10)(b) in that the resident plan of care was not revised when the resident's care needs changed as demonstrated by the following findings.
On a specified date, Resident #1 was reported to have sustained an injury. Staff #108 reported that it appeared that Resident #1 had sustained a cut. No bruising or swelling was noted at this time. There is documentation in Resident#1's progress notes for the next three days that described Resident #1 as having dark bruising and swelling.
Staff #112 #113, #102, #110 and #114 reported that Resident #1 received routine care for the next three days.
Staff members #102, #112 and #113 who provided care to Resident #1 for the next three days reported that the resident experienced pain during care because of the cut and the swelling.
Staff #113, #110 and #114 reported that they received no direction to provide other interventions to Resident #1 related to the swelling, bruising or cut.
There is no clinical documentation to indicate that Resident #1's plan of care was revised to address the bruising and swelling or the cut the resident sustained.
On the third day after the resident was discovered with the cut, the physician documented that Resident #1 had a traumatic looking lesion and prescribed an antibiotic. [s. 6. (10) (b)]

Issued on this 24th day of April, 2013

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

Lynda Hamilton