

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District

159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report	
Report Issue Date: May 23, 2024.	
Inspection Number: 2024-1441-0002	
Inspection Type: Critical Incident	
Licensee: Lakeland Long Term Care Services Corporation	
Long Term Care Home and City: Lakeland Long Term Care Services, Parry Sound	
Lead Inspector Amanda Belanger (736)	Inspector Digital Signature
Additional Inspector(s) Inspector Mikaela Parr (000874) was present during the inspection.	

INSPECTION SUMMARY
<p>The inspection occurred onsite on the following date(s): May 13-15, 2024.</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> One intake related to an allegation of improper/incompetent care of resident by staff.

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect

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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.

The licensee has failed to ensure that the plan of care set out for the resident provided clear direction to staff.

Rationale and Summary

The resident sustained a fall, and during the internal investigation, it was noted that the plan of care did not provide clear direction to the staff related to the resident care needs.

There was actual harm to the resident.

Sources: The resident's progress notes and care plan; internal investigation notes; Critical Incident (CI); and, interviews with the RPN, Director of Care (DOC), and other relevant staff.

[736]