Ontario

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2015	2015_287548_0027	O-002868-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

RUZICA SUBOTIC-HOWELL (548), AMBER MOASE (541), ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 16,17,18,19,20,23,24,25,26 and 27, 2015.

In concurrence with the Resident Quality Inspection, Complaint Log# O-00277-15 and Critical Incident Report (CIR)Log#:031465-15 were completed. During the course of the inspection, inspector(s) toured resident care areas, reviewed: residents' health care records, zero tolerance of abuse and neglect policy,restraint policy, continence and bowel management program, fall prevention program, internal incident & investigation documentation, reviewed resident personal equipment cleaning schedules, menus, observed meal service and medication administration.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care (DOC), Food Services Manager, Director of Support Services, RAI-MDS Coordinator, Environmental Services Manager, Environmental Services Staff, Dietary Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Nursing Assistants)NAs), Residents and Family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this act and the regulations is complied with.

On November 27, 2015 at the request of Inspector #531, the DOC provided the home's Restraint/PASD Use Policy #0401-05-09, Review date, June 2015. The policy indicated that for any resident who is physically, chemically or environmentally restrained, a Restraint/Repositioning Flow Sheet must be completed each shift by the RN, RPN and/or Nursing Attendant. The policy indicated that the applicable staff member are to document every 60 minutes while the resident is awake or more frequently as required, the removal of the restraint every 2 hours, repositioning/ambulation.

On November 27, 2015 at 11:10 hours Inspector #161 observed two nursing assistants (NAs) documenting on the home's flow sheets for several residents. Inspector #161 reviewed the Restraint/Repositioning Flow Sheets for twelve residents: #18, #20, #24, #51, #53, #61, #62, #63, #64, #65, #66 and #67. All twelve flow sheets had been prematurely completed to 14:00 hours. During an interview both NAs #137 and #138 indicated that premature documentation on each flow sheet was done because they know the residents' daily routines.

On November 27, 2015 Inspector #161 and the DOC discussed the premature completion of the flow sheets. The DOC agreed that that this is not acceptable practice at the home.

On November 27, 2015 Inspector #161 provided the Administrator resident's #51, #61 and #62 flow sheets. The Administrator reviewed the flow sheets and indicated that the matter would be rectified immediately.

On November 27, 2015 during an interview with Inspector #548 the DOC indicated that the home's documentation on restraints by nursing assistants and registered nursing staff is to be completed on the flow sheets and that the registered nursing staff document on the flow sheets the reassessment of the resident every 8 hours of the continued need of the restraint and in the resident's progress notes the effectiveness of the restraint and resident response. The DOC further indicated that the documentation in the progress notes is based on charting by exception such as; the resident is not responding well to the restraint or the restraint is not working well. The DOC indicated that documentation would "not necessarily be completed on an every eight hour basis".

The home's restraint policy, named above, specifies that reassessment of the resident every 8 hours of the continued need of the restraint is to be completed by registered nursing staff.

Inspector #161 reviewed the Resident's Restraint/Repositioning Flow Sheets and progress notes for three residents #51, #61 and #62 for a specific time period in November, 2015. The flow sheets indicated that these residents had been physically restrained during specified times during this period of time and a review of the progress notes indicated that there was no documentation of the effectiveness of the restraint nor the resident's response to the physical restraint.

As such, the licensee has failed to ensure that the home's policy on restraints was complied with. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure compliance with the home's restraint policy specific to the documentation as outlined finding #1, to be implemented voluntarily.

WN #2: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that 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: (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.

On a specified day in October, 2015 the MOHLTC received a call and on a specified day in November, 2015 a Critical Incident Report regarding the same altercation incident involving two residents that resulted in an injury to resident #041.

The home has a process in place to contact the MOHLTC to submit a CIR, a shared responsibility amongst the registered nursing staff members, Assistant Director of Care (s) and the Director of Care.

The health care record was reviewed. A progress note entry dated on a specified day in October, 2015 indicated that resident #041 informed a registered nursing staff member that co-resident #042 was found in his/her room swinging his/her arms in the air towards resident #041, "attempting to slap him/her". Subsequently, the following day the resident #041 reported to a registered nursing staff member that he/she had a "defensive physical contact" with the co-resident #042. Details recorded included that resident #041 required emotional support and counselling due to the incident.

On November 26, 2016 the DOC indicated that she investigated the incident and her initial impression was that there was no harm done to resident #041 and from the interviews there were mixed details of what happened between the two residents. The DOC provided to Inspector #548 her investigative notes. Review of the DOC investigative notes dated the following day of the incident, indicated that resident #041 reported to the DOC that he/she suffered physical injury from the altercation and resident #042 made moves to strike him/her. A few days later, an email message directed to the DOC from a registered nursing staff member indicated that resident #041 was "frightened" from the incident and remained fearful of its reoccurrence.

On November 27, 2015 during an interview RN#133 indicated that the home has a procedure and policy on what type of incident needs reporting to the MOHLTC. RN #133 indicated that any risk of harm or actual harm is to be reported. RN#133 indicated that the incident should have been immediately reported as there was a potential and actual risk of harm to resident #041. Review of the policy titled: Critical Incident Reporting, #0202-12-01, Review date: January 2012 indicated the same.

On a specified day in November, 2015 during an interview resident #041 indicated that resident #042 is a resident that is known by staff to wander into other resident rooms and on the day of the incident there was a physical altercation between the two where injury was sustained. Resident #041 indicated that he/she is not afraid of resident #042 at this time.

As such, the licensee failed to immediately report an incident where there is reasonable grounds to suspect abuse, emotional and physical of a resident that resulted in harm or risk of harm. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent has an individual plan, as part of his or her plan of care, to promote and manage bowel and bladder incontinence based on the assessment and that the plan is implemented.

On November 27, 2015 discussion held with RPN #139 and several PSW's regarding the incontinence needs, during an afternoon rest, of 10 cognitively impaired residents (051, #052, #053, #054, #055, #056, #057, #058, #059, #060). The staff indicated that these resident's incontinence needs during their afternoon rest are met by dressing each resident in either a shirt with a continence product; or a shirt, a continence product, their pants pulled down mid-thigh or below their knees; and covering them with a blanket. The staff indicated that in this manner, (1) it is easier for them to observe if a resident's continence product needs to be changed and (2) it is easier for them to change the resident as the residents are less combative and agitated.

A review of each of the 10 resident's incontinence plans of care indicated that their plan of care had not been individualized based on an assessment of the resident's incontinence needs while having an afternoon rest, to include a state of undress. [s. 51. (2) (b)]

Issued on this 11th day of December, 2015

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

Original report signed by the inspector.