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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 19, 2016	2016_280541_0021	004572-16/024668-16	Complaint

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

AMBER LAM (541)

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): August 17 and 18, 2016

Two complaint logs were inspected, both concerns regarding resident care and staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, an Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Residents. In addition the inspector also observed staff to resident interactions, reviewed resident health care records, reviewed relevant policies and reviewed the home's staffing plan.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero

tolerance of abuse and neglect of residents and that it is complied with.

On a specified date it was documented in resident #002's progress notes that resident #003 was witnessed grabbing both of resident #002's hands. Resident #002 sustained a specified injury which was treated by the RPN responding to the incident.

On another specified date it was documented in resident #002's progress notes that the resident was in the hallway yelling "help". A Mobile Response Team (MRT) staff responded and resident #002 stated "he/she grabbed me". The MRT staff person witnessed resident #004 walking out of resident #002's room. Resident #002 was noted to have an injury.

Upon review of the MOHLTC Critical Incident Reporting system, it was confirmed that the Director was not informed of the above incidents.

As per O. Reg 79/10 s. 2(1) physical abuse means (c) the use of physical force by a resident that causes injury to another resident.

Inspector #541 requested the home's policy for prevention of abuse, neglect and retaliation and was provided with policy #0202-02-05 titled "Abuse and Neglect of Residents". Page 1 of the policy includes the definition of physical abuse as per O. Reg 79/10 s. 2(1)c. Page 12 of the policy states that the incident investigation team in conjunction with the Administrator/delgate will:
7. Ensure that a MOHLTC Critical Incident Report is completed and reported as per the Home's procedure for reporting to the MOHLTC.

RN #101 was the RN in charge on the date of one specified incident. RN #101 was interviewed regarding the incident and did not recall being aware of it. The Associate Director of Care (ADOC #102) responsible for the unit where the residents reside was interviewed regarding the incident. ADOC #102 indicated that she found out about the incident the next morning and was told that resident #002 sustained an injury that was treated. When asked why she did not report the incident to the Director, ADOC #102 stated that because she later found out that the resident's specified injury was not new and had just re-opened as a result of the incident she did not consider the incident to be abuse. Inspector #541 reviewed resident #002's progress notes and there was no indication that resident #002's specified injury was assessed to be an old injury that had re-opened. The Director of Care (DOC) was interviewed regarding the incident and stated that she would not consider the specified injury that opened as a result of the

incident to be considered physical abuse.

The Director of Care (DOC) was interviewed regarding the incident that occurred on the other specified date. The DOC did not recall being aware of the incident but when Inspector #541 reviewed it with her, the DOC did state she would not consider the specified injury on resident #002 to be an injury. When Inspector #541 requested further documentation for the incident the DOC stated there was only the progress note.

As per the definition of physical abuse, the incidents on two specified dates are considered resident to resident physical abuse and therefore should have been immediately reported to the Director. [s. 20. (1)]

Issued on this 19th day of August, 2016

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

Original report signed by the inspector.