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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_702197_0003	018941-17, 021320-17	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

JESSICA PATTISON (197)

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): October 20, 23-26 (on-site), November 6, 7 (off-site) 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Care (ADOC), the Activation Manager and activation staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), an external Personal Care Provider, Housekeeping staff, residents and resident family members

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 3(1)(11)(iv) in that residents in specific home areas have not had his or her personal health information kept confidential.

On a specified date, a family member gave the inspector two copies of Resident Care Worksheets used by PSW's that included personal health information for residents that reside on a particular home area. The family member indicated these had been left in their family member's room by staff. The family member also indicated having seen these sheets out in the hallway on carts.

On October 26, 2017, the inspector took a tour and found that on two specified home areas the Resident Care Worksheets, with resident personal health information, were present on clean linen carts, visible to anyone walking by and therefore, not kept confidential. [s. 3. (1) 11. iv.]

WN #2: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that the plan of care for resident #001 does not set out clear directions to staff and others who provide direct care to the resident.

On a specified date, during the evening shift, resident #001 sustained an injury.

The following day, RPN #102 indicated in a progress note that the resident stated they would notify their Power of Attorney (POA) of the injury.

Incident note made by RN #103 two days after the injury occurred indicates that resident #001's POA was made aware of the incident that evening.

Resident #001's POA indicated to the inspector that they were upset the home did not notify them sooner of the injury. The POA said it wasn't until arriving at the home two days after the incident that they were made aware of the injury by the resident.

Inspector noted that on the front of the resident's paper chart were two notes for staff: The first note was dated before the injury occurred and stated that the POA requests to be called at any time with any concerns regarding resident. POA still wishes to be called if on occasion the resident does request that POA not be disturbed. Thank you.

The second note is dated just after the injury occurred and states that staff need to be sure to contact POA about any changes to medications, resident's condition, incidents, physicians orders, and/or anything new to report. This note was written by ADOC #106.

Interviews with staff on resident #001's home area and with management indicated the following:
RN #104 stated that the resident is capable so if he/she says they will call the POA then that is ok. However, she states she usually calls the POA anyway and would have called them about this had she been the one to discover the injury.

RN #103 stated that because the resident is capable of making their own decisions, the staff respect the right to choose whether he/she wants the POA to be notified.

RPN #105 who worked the evening shift and discovered the injury stated that the resident told her not to call the POA, so she did not.

RPN #102 who worked the day shift following the injury to the resident, stated that she was unsure if resident #001's POA had been notified of the injury. She said the resident told her not to bother the POA and that he/she would tell them. She further stated that the person who sees the injury should call the POA, but they should ask the resident if the resident is capable.

ADOC #106 stated that the resident's POA does like to be notified of changes with the resident and that they were upset about not being notified in this case. She further stated she had no concerns with how the process was handled by staff.

During an interview with resident #001 during the inspection, he/she indicated to the inspector that they were fine with staff contacting their POA anytime. The resident further stated he/she wants their family to be aware.

The plan of care for resident #001 does not provide clear direction to staff related to if and when they should contact the POA for the resident. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care was not provided to resident #002 as specified in the plan.

Resident #002's care plan indicates that they are dependent on staff for locomotion and that they require monitoring and assistance for certain aspects of eating meals.

A complaint was made to the inspector that resident #002 had been left in the dining room after a particular meal for a prolonged period of time on two separate occasions.

During an interview with the resident's personal care provider, hired by the resident's family, he/she indicated that they found the resident on these two occasions approximately two hours after the meal each time, alone in the dining room. The personal care provider stated that there was a housekeeper present (#100) on one occasion and provided the name. The personal care provider also said there was a dietary aide present on the other occasion but could not recall their name.

Housekeeping staff #100 indicated to the inspector during a telephone interview that she did recall a time when resident #002's private caregiver did come and found the resident alone with no staff and no other residents in the dining room. The housekeeper further stated she could not recall any further details.

The Assistant Director of Care (ADOC) #101 was interviewed during the inspection related to resident #002 being left in the dining room. She recalled a time when she was doing her rounds and found the resident still in the dining room after a particular meal. The ADOC stated the resident still had food and beverages in front of them and there were no staff in the dining room. The ADOC indicated that she sat with the resident, assisted them with the rest of the meal and then took the resident back to their room.

ADOC #101 also wrote progress notes on three specific dates as follows:

- Resident is on a specified eating program. Requires time and assistance to finish meal. Resident requires specified monitoring following meal.
- Resident was left in dining room following a specified meal. PLAN: Resident to be removed from dining room following meals and placed in their room.
- Resident's family member spoke with writer (ADOC) about displeasure that resident was left sitting in the dining room for two hours following meal yesterday. Staff to ensure that resident is removed from the dining room after meals.

Care was not provided to resident #002 as specified in the plan since staff did not remain with the resident in the dining room to provide monitoring and required assistance to finish the meal. The resident was also not provided with the assistance required to get back to their room after the meal. [s. 6. (7)]

3. The licensee has failed to comply with LTCHA 2007, s. 6(9)1 in that a provision of care set out in the resident's care plan with respect to oral/dental care was not documented.

Resident #002's care plan related to personal hygiene instructs staff to assist resident with oral care each morning and evening.

The daily care flow sheets for resident #002 were reviewed for a specified period of time. It was noted that 58% of the time, oral care was not documented for the resident. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 131(1) in that resident #001 received a medicated treatment that was not prescribed.

On a specified date, RPN #107 was training a new RPN, #108, during treatment pass. RPN #108 applied a medicated treatment to resident #001 when there was no physician's order. The medication incident report indicates that the treatment was meant for another resident.

Resident #001's family member indicated that he/she was present when RPN #108 arrived to apply the treatment and questioned the RPN since they were unaware of the treatment being ordered for the resident. Resident #001's family member reported that RPN #108 continued to apply the treatment without checking the treatment administration record (TAR). The family member of resident #001 stated that a few minutes later RPN #107 returned to the resident's room and removed the medicated treatment from resident #001. [s. 131. (1)]

Issued on this 8th day of November, 2017

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

Original report signed by the inspector.