Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St., 4th Floor
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347, rue Preston, 4iém étage
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 12, 13, and 14, 2011	2011_042148_0001	Critical Incident

Licensee/Titulaire
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, Brackville, ON, K6V 5T1

Name of Inspector(s)/Nom de l'inspecteur(s)
Amanda Nixon (148) and Brenda Thompson (175)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Assistant Director of Care responsible for Pine Unit, Nutritonal Manager, 2 Registered Practical Nurses, 2 Personal Support Workers and 2 Dietary Aides responsible for Pine Unit.

During the course of the inspection, the inspector(s) reviewed the health care record of an identified resident including Medical Certificate of Death – Form 16, the home's investigation notes and staff written statements related to the critical incident, policies and procedures as follows: Level of Care Directives, Critical Incident Reporting, Manager on Call Coverage, Dysphagia Management, Guidelines for Cardio-Pulmonary Resuscitation Recertification, House Diets; first floor staff assignment sheet, Week 1 Saturday menu and production sheet, Registered Dietitian Menu Approval, General Guidelines for Nursing Attendants and Registered Staff Assigned Medications Evenings.

The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident Response
Nutrition and Hydration
Safe and Secure

Findings of Non-Compliance were found during this inspection. The following action was taken:

2WN
1 CO: CO #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents Specifically failed to comply with the following subsections:

s.107(1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or

flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as deined in the Health Protection and Promotion Act.
6.Contamination of the drinking water supply. O.Reg. 79/10, s. 107(1).

Findings:

As indicated by the Medical Certificate of Death, the identified resident died unexpectedly on the evening of Saturday, April 9, 2011. Immediate cause of death, choking.

The Registered Nurse, responsible for the care of the resident on April 9, 2011, informed the Manager on call, the Assistant Director of Care, of the unexpected death the evening of April 9, 2011.

The Assistant Director of Care notified the Director at 0900 hours on April 11, 2011. Two days after the death of the resident.

Inspector ID #:	148 and 175

WN #2: The Licensee has failed to comply with O.Reg 79/10, s.8 Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s.8 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is compiled with. O.Reg.79/10, s.8(1)

Findings:

Under O.Reg 79/10, s.30(1) the licensee is required to have policies and procedures, and provide for methods to reduce risk to residents under the program of nursing care and services.

The home's Level of Care policy, Policy # 0401-05031, indicated that in the event of "illness or injury" one of the three levels of care will be selected by the resident to direct care providers.

Interview with Tracy Davidson, on April 13, 2011, stated that choking does not fit into "illness or injury", as it relates to the Level of Care Directive.

The resident's Level of Care Directive was a Level 2, indicating transfer to hospital without cardiopulmonary resuscitation.

The Medical Certificate of Death, completed by the Coroner on April 9, 2011, indicated that the resident's immediate cause of death was choking.

Progress note dated April 9, 2011 written by the Registered Nurse responsible for the care of the resident,

indicated that due to the Level of Care status and pulses absent for 5 minutes or more, the Registered Nurse provided direction to cease attempts at the Heimlich. This is contrary to the home's Level of Care policy.

Inspector ID #:	148 and 175

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** L Thompson and Amanda Rex
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 2, 2011.

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Amanda Nixon and Brenda Thompson	**Inspector ID #**	148 and 175
Log #:	000778		
Inspection Report #:	2011_042148_0001		
Type of Inspection:	Critical Incident		
Date of Inspection:	April 12, 13 and 14, 2011		
Licensee:	The Corporations of the united Counties of Leeds and Grenville, the City of Brockville, the Town of Gananaque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, Brockville, ON, K6V 5T1		
LTC Home:	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, Brockville, ON, K6V 5T1		
Name of Administrator:	Tom Harrington		

To The Corporations of the united Counties of Leeds and Grenville, the City of Brockville, the Town of Gananaque and the Town of Prescott, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to

O.Reg 79/10, s.8 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is compiled with. O.Reg.79/10, s.8(1)

Order:

The licensee shall ensure that the Level of Care policy is complied with.

Grounds:

Under O.Reg 79/10, s.30(1) the licensee is required to have policies and procedures, and provide for methods to reduce risk to residents under the program of nursing care and services.

The home's Level of Care policy, Policy # 0401-05031, indicated that in the event of "illness or injury" one of the three levels of care will be selected by the resident to direct care providers.

Interview with Tracy Davidson, on April 13, 2011, stated that choking does not fit into "illness or injury", as it relates to the Level of Care Directive.

The resident's Level of Care Directive was a Level 2, indicating transfer to hospital without cardiopulmonary resuscitation.

The Medical Certificate of Death, completed by the Coroner on April 9, 2011, indicated that the resident's immediate cause of death was choking.

Progress note dated April 9, 2011 written by the Registered Nurse responsible for the care of the resident, indicated that due to the Level of Care status and pulses absent for 5 minutes or more, the Registered Nurse provided direction to cease attempts at the Heimlich. This is contrary to the home's Level of Care policy.

This order must be complied with by:	May 3, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28

days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 2nd day of May , 2011.	
Signature of Inspector:	B Thompson and Amanda Nixon
Name of Inspector:	B. THOMPSON and Amanda Nixon
Service Area Office:	OTTAWA