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

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Inspection de soins de longue durée

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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
Jul 6, 2018	2018_664602_0011	009655-18	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

WENDY BROWN (602), AMBER LAM (541), JESSICA PATTISON (197), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 29 - 31 & June 1, June 4 - 8 and 11 - 15, 2018

The following critical incidents were completed concurrently with the Resident Quality Inspection:(RQI):
003566-18 - fall with injury requiring hospitalization
007672-18 - fall with injury requiring hospitalization

The following complaints were completed concurrently with the RQI:
004272-18 - resident choking
005124-18 - resident behaviours
005620-18 - refusal of admission
005681-18 - resident behaviours
006404-18 - plan of care
007550-18 - activities, trust accounts and fall with injury requiring hospitalization
008210-18 - resident behaviours
008558-18 - resident behaviours
009030-18 - resident behaviours
009361-18 - neglect, medication, staffing plan of care and reporting/complaints
009395-18 - skin & wound and oral care
009586-18 - neglect, medication, staffing plan of care and behaviours

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), environmental services, the Assistant Directors of Care (ADOC), the Director of Care (DOC), dietary aides, the Physiotherapist (PT), the Registered Dietitian (RD), the Food Services Supervisor (FSS), Business Office Staff and the Administrator

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation
Trust Accounts

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

- **10 WN(s)**
- **7 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The following finding is related to log #004272-18:

On a specified date, resident #056 was served a restricted food which resulted in a choking spell. A progress note written on that date indicated while resident #056 was choking, RPN #121 provided the resident with sips of ice water. The resident continued to be monitored and a respiratory concern was noted. At a subsequent meal, resident #056 attended the dining room, and further respiratory issues were noted. At that time, RPN #121 provided the resident with ice ginger ale. The resident continued to show signs of respiratory distress and was sent to hospital. According to resident #056's plan of care, the resident's diet order on a specified date was puree texture, pudding thick fluids and other specific food restrictions.

Resident #056 was identified as being at unstable high nutritional risk. The resident was also noted as having a significant cognitive impairment.

Resident #056 had a long history of difficulty swallowing as per review of the resident's health care record. Resident #056 was admitted to the hospital on a specified number of occasions following choking episodes. Upon a return from the hospital, resident #056's diet order was modified by the home's RD to remove certain foods due to risk of choking.

The home's Registered Dietitian was interviewed and indicated that residents on pudding thick fluids would only be provided with regular water if they were on a water protocol and would only be provided the water in between meals and never with food. The RD further stated resident #056 was not on a water protocol due to high risk of choking.

RPN #121 was interviewed and indicated the ice water and ice ginger ale were provided to resident #056 in hopes of assisting the resident cough up any food that had not gone all the way to the resident's lungs.

Resident #056 returned from the hospital on a specified date, deemed as palliative and was to receive nothing by mouth. The resident passed away a specified number of days later.

The licensee failed to ensure the care set out in resident #056's plan of care was provided to the resident as specified in the plan. Resident #056 plan of care indicates the resident was to receive puree texture, pudding thick fluids and certain specific foods . On a specified date, resident #056 was provided a restricted food, ice water and ice ginger

ale. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistant Safety Device (PASD) under subsection (3) to assist a resident with a routine activity of living was

included in the plan of care before the following were satisfied:
1. Alternatives to the use of a PASD were considered.
2. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario.
3. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

Resident #004 was admitted to the home several specified years ago. During the RQI inspection, resident #004 was observed in the wheelchair wearing a front closing seatbelt. Resident #004 was unable to remove the seat belt independently on a specified date when asked to do so by an inspector.

In interviews on June 5, 2018, RN #104, RPN #105 and PSW #106 each indicated that resident #004 required the front closing seat belt for positioning purposes.

The residents plan of care specific to restraints and PASDs was reviewed; there was no reference to the use of a seat belt (PASD) for resident #004. There was no evidence found to support that alternatives to the seat belt were considered, and tried where appropriate, and there was no indication that the use of the PASD was approved by a physician, registered nurse, registered practical nurse, occupational therapist or physiotherapist. The PASD/restraint binder did not list resident #004 as having a PASD.

The plan of care was revised, by home staff, on a specified date during the RQI inspection to include the use of a seat belt, as a PASD. Progress notes on the specified date indicated the resident wears a seat belt while in the wheelchair due to sliding down in the chair. The family was contacted on the specified date and provided consent for use of the PASD.

A PASD for resident #004 was in use prior to satisfying the following: alternatives to, approval of, and consent for the use of a seat belt. [s. 33. (4) 1.]

2. The following finding is related to log #009361-18:

Resident #051 was admitted to the LTC home on a specified date. At admission, the resident required assistance with some activities of daily living and could ambulate with the assistance of an ambulatory aid. Resident #051 required a wheelchair, "at times",

due to various physical limitations. Family expressed their wish that the wheelchair be used only when essential, as they felt maintenance of resident #051's ambulation level through regular use of an ambulatory aid was important; despite this, the resident's SDM signed the home's consent for restraint/PASD form at admission allowing use of a seat belt, that can be undone, while the resident was using a wheelchair.

During a specified date, resident #051's family reviewed their wish, to maintain resident #051's ambulation level, with RN #117. On a subsequent specified date, resident #051's SDM revisited family concerns with ADOC #102 regarding "overuse" of the wheelchair and seat belt. The SDM requested that resident #051 only use the wheelchair in times of fatigue and removed the consent for use of the PASD (seat belt) . The following interdisciplinary team conference summary documented that consent to the use of the resident's seat belt was removed. In an interview with inspector #602, the SDM indicated that despite family requests, resident #051 was found to be sitting in a wheelchair, with a seat belt on, at most visits to the home. They advised they continued to express concerns about maintaining ambulatory status for a specified period, with no change to care plan.

There was no evidence to show that use of the seat belt /wheelchair was discussed with family until a specified date. The admission restraint/PASD consent form was not revisited despite family withdrawal of consent. Interviews with RN #117, PSW #118 & #119 and a hard copy chart review both indicate that resident #051 has worn a seat belt, that can not be undone independently, while sitting in wheelchair, since admission.

The SDM's withdrawal of consent for use of the PASD was not followed. [s. 33. (4) 4.]

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 that alternatives to the use of PASD's have been considered, the use has been approved by a physician, registered nurse, registered practical nurse, a member of the college of occupational therapists or physiotherapists, and consent to the use of the PASD has been obtained from the resident/resident's SDM, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #018 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On a specified date, a skin assessment was completed for resident #018 using a specific wound assessment tool which indicated the resident had a specified stage wound and that the area had deteriorated. Comments on the assessment indicated this was the initial assessment of the area. There were no further skin assessments noted for resident #018 until a specified date.

According to resident #018's plan of care, the resident had potential for altered skin integrity related to various physical impairments; PSW staff were to inspect all skin surfaces daily during care and notify registered staff of any skin problems/changes.

Inspector #541 requested the home's policy related to skin assessment and was provided with policy #0401-05-43 titled Pressure Ulcer/Wound Treatment which states the following under Procedure:
"For Stage II, III, IV and X wounds, the Registered Staff will document weekly assessment on the pressure ulcer/wound assessment table."

ADOC #102 was shown the wound assessment tool and was asked if there was documentation completed elsewhere for resident #018's wound. ADOC #102 stated if it was not documented on the tool it was not done. Inspector #541 reviewed resident #018's progress notes during a specified period and there was no documentation related to the resident's skin condition.

As of a specified date, resident #018's wound deteriorated to a specified stage.

The licensee failed to assess resident #018's wound weekly, as clinically indicated as per policy #0401-05-43, during a specified period.

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 residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,receive weekly skin assessments by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council meeting minutes for a specified period were reviewed. It was noted during one meeting, a concern related to was brought forward and stated:
There was no evidence in the Residents' Council binder / minutes that a response to this concern had been given to the Council.

The Activation Coordinator was interviewed and stated that a written response has not yet been made to the council in relation to this concern.

The licensee did not respond in writing within 10 days of receiving the concern from the Council. [s. 57. (2)]

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 that within ten days of receiving advice of Council concerns or recommendations, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #541 spoke with a Council member who states the home's Administrator attends all meetings and will either address concerns at the meeting or if unable, will address the concern at the next meeting.

Inspector #541 reviewed the family council meeting minutes for the previous 3 meetings; six concerns were raised and a response was not provided to the Council for a period of weeks. During a subsequent meeting, two further concerns were raised and no written response has been provided to date:

Inspector #541 spoke with the home's Administrator who attends all Family Council meetings and responds to the concerns at the time if able. The Administrator further stated if more information is required prior to responding to the issue, the response will be provided at the next Family Council meeting. [s. 60. (2)]

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 that within ten days of receiving advice of Council concerns or recommendations, respond to the Family Council in writing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutritional care and hydration program included a weight monitoring system to measure and record, with respect to each resident, their height on admission and annually thereafter.

A health care record review was completed for forty residents in the home. It was noted

by the inspection team that twenty-five out of the forty residents reviewed, did not have a documented annual height since their admission. The last dates that heights were documented for these residents was as follows:

Resident #003 - August 30, 2016
Resident #004 - May 22, 2012
Resident #007 - June 6, 2016
Resident #008 - July 15, 2016
Resident #009 - October 14, 2016
Resident #010 - December 3, 2014
Resident #011 - January 8, 2016
Resident #012 - January 29, 2013
Resident # 013 - March 26, 2013
Resident #014 - August 12, 2015
Resident #016 - December 14, 2016
Resident #018 - April 1, 2015
Resident #020 - November 12, 2012
Resident #021 - January 6, 2015
Resident #022 - May 22, 2012
Resident #024 - September 13, 2016
Resident #026 - November 14, 2016
Resident #027 - March 1, 2016
Resident #028 - March 6, 2015
Resident #030 - June 29, 2016
Resident #031 - December 9, 2014
Resident #032 - November 1, 2016
Resident #033 - February 11, 2014
Resident # 036 - May 18, 2016
Resident #038 - May 22, 2012

In an interview on June 15, 2018, the Director of Care stated that it is their expectation that annual heights are completed and documented. The DOC indicated that the home does have process in place to measure annual heights but the staff member responsible is currently off on leave. The licensee failed to ensure a system to monitor annual heights for 25 of the 40 residents sampled was in place. [s. 68. (2) (e) (ii)]

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 a weight monitoring system to measure and record, with respect to each resident, their height on admission and annually thereafter., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of the incident of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The following finding is related to log #004272-18:

On a specified date, resident #056 was served a restricted food which resulted in a choking spell. A progress note written on that date indicated while the resident was choking, RPN #121 provided the resident with sips of ice water. At a subsequent meal, resident #056 attended the dining room and was having respiratory difficulties while starting to eat. At that time, RPN #121 provided resident with ice ginger ale with no resolution of respiratory distress. Resident #056 was sent to hospital due to decline health status.

Inspector #541 reviewed the Ministry of Health and Long-Term Care's Critical Incident reporting system and was unable to find a critical incident submitted for this incident. The home's Director of Care was interviewed and confirmed the home did not submit a critical incident for the incident. [s. 107. (3)]

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 ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented.

Resident #047 was admitted to the home on a specified date with multiple identified diagnoses. During a review of resident #047's MAR inspector #541 noted that a specified number of medications were not administered on a specified shift.

Resident #047's MAR was reviewed together with ADOC #101. After following up with unit nursing staff, ADOC #101 explained that staffing issues on the specified shift and required the Registered Nurse (RN)/Nurse in charge administer the medications on resident #047's unit rather than the usual Registered Practical Nurse (RPN). The RN forgot to sign the appropriate location on resident #047's MAR. The error was noted on the following shift, however, an incident report was not completed. [s. 135. (1)]

2. Resident #049 was admitted to the home on a specified date with multiple diagnoses. On a subsequent specified date, resident #049's 2100 hour dose of a specific medication was not given.

The medication incident report Policy 0401-02-07, reviewed February 2018, indicates under procedure that "when a medication incident/ /discrepancy is discovered, the person discovering the incident initiates the appropriate Incident Report". The procedure further directs the person initiating the report to "complete all of the applicable sections on the report" including notification of resident/POA.

A review of the Medication Administration Record (MAR), the associated medication incident report and progress notes was completed with ADOC #103 who confirmed that the medication was not given as prescribed. In addition, it was agreed that there was no evidence that resident #049's Substitute Decision Maker (SDM) was notified of the error. [s. 135. (1)]

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 that every medication incident involving a resident and every adverse drug reaction is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, to be implemented voluntarily.

WN #9: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that medications were given to residents #050 and #049 in accordance with directions for use specified by the prescriber.

Resident #050 was admitted to the home on a specified date with multiple diagnoses. On a specific date, resident #050 was given an extra dose of a medication. During an interview with Inspector #602, ADOC #103 indicated that resident #050 received an additional does of a the medication as a result of confusion and interruptions by multiple individuals at the medication cart. The licensee failed to administer medications as specified by the prescriber. [s. 131. (2)]

2. Resident #049 was admitted to the home on a specified dates with multiple diagnoses. On a specified date resident #049's did not receive a dose of a medication. On review of the Medication Administration Record (MAR), the associated medication incident report and progress notes, ADOC3 confirmed that the medication was not given as prescribed. The licensee failed to ensure that medication was administered as prescribed. [s. 131. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The following finding is related to log 009586-18:

The licensee has failed to ensure that before discharging a resident under subsection 145 (1) that they:
(b) collaborated with other health service organizations to make alternative arrangements for accommodation, care and secure environment required by the resident,
(c) ensured the resident's SDM (substitute decision-maker) was kept informed and given an opportunity to participate in the discharge planning and that their wishes were taken into consideration
(d) provided a written notice to the resident's SDM setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

On a specified date, resident #049 was sent to hospital for assessment after demonstrating responsive behaviours. The resident was admitted to hospital and a specified number of days later, the resident's progress notes indicate that the resident

was able to be discharged back to the home. The following day, the Director of Care documented in the progress notes that they spoke to an RN at the hospital and informed them of the home's decision not to accept the resident back due to their inability to manage the resident's care needs. The notes also indicate that the DOC followed-up with the Power of Attorney (POA) to inform of the discharge. There was no documentation indicating that the POA was given an opportunity to participate in the discharge planning process.

The POA for care of resident #049 indicated to the inspector that they did not feel the home worked with the hospital or with the family as part of the discharge process. The POA also stated that in the phone call from the DOC informing them of resident #049's discharge, that no other options were provided and no support was given related to what they could do about finding a suitable placement for the resident.

The Discharge Planner for the hospital informed the inspector that in their opinion the home had the right to discharge the resident but it was their understanding that the home should then assist with other placement. The Discharge Planner indicated that the Director of Care was asked to be a part of the discussion related to an appropriate placement for resident #049 but declined.
Resident #049's chart was reviewed and there was no evidence of a written notice to the resident's SDM setting out a detailed explanation to justify the licensee's decision to discharge the resident.

During an interview with the Director of Care for the home, they indicated that the home had not provided a written notice to resident #049's SDM related to the discharge. The DOC indicated they did not participate in further discussions about appropriate placement for the resident with the hospital. The DOC stated that since the resident was not coming back to St. Lawrence Lodge, they did not know what role they would have played in the discussion. When asked about the conversation with the resident's SDM about discharge, they stated they did not know who else or what other info could have been provided. The DOC stated that the SDM was already in touch with the discharge planner and the CCAC (Community Care Access Centre) at the hospital. The DOC further stated that SDM of resident #049 did not voice any concerns at the time they were informed of the discharge.

There was no evidence that the licensee collaborated with the hospital in the discharge process, no evidence that the home gave the SDM an opportunity to participate fully in the discharge planning and the home did not provide a written notice to resident #049's

SDM with justification of the licensee's decision to discharge the resident. [s. 148. (2)]

Issued on this 26th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), AMBER LAM (541), JESSICA PATTISON (197), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2018_664602_0011
Log No. / No de registre :	009655-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 6, 2018
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
LTC Home / Foyer de SLD :	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Harrington

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.
Specifically the licensee shall ensure that all residents are provided the texture modified diet in accordance with their plan of care

Grounds / Motifs :

1. The licensee has failed to ensure that care set out in the plan of care provided to the resident as specified in the plan.

The following finding is related to log #004272-18:

On a specified date, resident #056 was served a restricted food which resulted in a choking spell. A progress note written on that date indicated while resident #056 was choking, RPN #121 provided the resident with sips of ice water. The resident continued to be monitored and respiratory difficulties were observed. At a subsequent meal, resident #056 attended the dining room, and further respiratory symptoms were noted. At that time, RPN #121 provided resident with ice ginger ale. The resident continued to show signs of respiratory distress and was sent to hospital. According to resident #056's plan of care, the resident's diet order included puree texture, pudding thick fluids and certain food restrictions.

Resident #056 was identified as being at unstable high nutritional risk. The resident also had a significant cognitive impairment.

Resident #056 had a long history of difficulty swallowing as per review of the resident's health care record, including assessments by the home's Registered Dietitian (RD). Resident #056 was admitted to the hospital on two occasions

following a choking episodes. Upon return from the hospital, resident #056's diet order was modified by the home's RD to remove specific foods due to risk of choking.

The home's Registered Dietitian was interviewed who indicated that residents on pudding thick fluids would only be provided with regular water if they were on a water protocol and would only be provided the water in between meals and never with food. The RD further stated resident #056 was not on a water protocol due to high risk of choking.

RPN #121 was interviewed and indicated the ice water and ice ginger ale were provided to resident #056 in hopes of assisting the resident cough up any food that had not gone all the way to the resident's lungs.

Resident #056 returned from the hospital on a specified date, was deemed palliative and was receiving nothing by mouth. The resident passed away a specified number of days later.

The licensee failed to ensure the care set out in resident #056's plan of care was provided to the resident as specified in the plan. Resident #056 plan of care indicates the resident was to receive puree texture, pudding thick fluids and certain specific foods. On a specified date, resident #056 was provided a restricted food, ice water and ice ginger ale.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #056. The scope of the issue was a level 1 as only one resident was affected. The home has a level 3 compliance history as the home had 1 or more related non-compliance over the past 36 months that includes:
- Written Notification (WN) issued October 18, 2017 (2017_702197_0003)
- Voluntary Plan of Correction (VPC) issued December 1, 2017 (2017_702197_0012)
(541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
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Name of Inspector /
Nom de l'inspecteur : Wendy Brown

Service Area Office /
Bureau régional de services : Ottawa Service Area Office