Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2020	2020_505103_0002	022423-19, 024446-19, 000688-20	Critical Incident System

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 19-21, 24, 2020.

Log #022423-19 (CIS #M576-000024-19) and Log #000688-20 (CIS #M576-000002-20)-incidents of alleged resident to resident abuse,
Log #024446-19 (CIS #M576-000026-19)-resident fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with a family member, Personal Support Workers (PSW), an Activationist, Registered Practical Nurses (RPN), the Assistant Director of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspector reviewed resident health care records and the critical incidents submitted regarding the incidents, made resident observations and reviewed the licensee's abuse policy, "Abuse and Neglect of Residents, #0202-02-05" last revised in May 2019.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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 their abuse policy was complied with.

On an identified date, resident #002 was suspected of pushing resident #003. Resident #003 sustained an injury and was transferred to hospital for additional treatment. During a review of resident #003's resident health care record and the critical incident submitted to report this incident, it was noted the police were not immediately notified of the incident.

The licensee's abuse policy, "Abuse and Neglect of Residents, #0202-02-05" last revised in May 2019 was reviewed. Under "Procedures-First Actions", the policy states, "the manager/delegate receiving the complaint will inform the resident of the home's obligation to contact the police as per the requirements of the Long-Term Care Homes Act, if the licensee suspects that the alleged, suspected or witnessed incident of abuse or neglect may constitute a criminal offence."

This inspector spoke with DOC #106 who stated the home believed the incident constituted a criminal offense (assault) but did not immediately notify the police at resident #003's family member's request. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force was immediately notified of the suspected incident of physical abuse between resident #002 and #003 as legislatively required.

As outlined in WN #001, the police were not immediately notified of the suspected abuse that occurred between resident #002 and #003.

Discussion was held with DOC #106 who stated resident #003's family member requested the police not be notified and the home respected that decision. DOC #106 stated the same family member notified the police a few days later of the incident. [s. 98.]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.