

**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**

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

**Public Copy/Copie du rapport public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
May 26, 2020	2020_505103_0007	009742-20	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): Off-site inspection was completed on May 21, 22, 25, 2020.**

**Log #009742-20 (CIS #M576-000016-20)-resident injury that resulted in transfer to hospital.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), a Registered Practical Nurse (RPN), a Registered Nurse (RN) and the Director of Care (DOC).**

**During the course of the inspection, this inspector reviewed the Info-line report, the critical incident regarding this incident, and the resident's health care record.**

**The following Inspection Protocols were used during this inspection:  
Personal Support Services**

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

**1 WN(s)  
1 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.

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure PSW #100 used safe positioning techniques while providing care to resident #001.

On an identified date, PSW #100 was providing morning care to resident #001. PSW #100 was interviewed and stated they were preparing the resident to get out of bed and had positioned the resident onto their side to facilitate the placement of their transfer sling. PSW #100 stated they took two to three steps away from the bed to reach the sling and while doing so, resident #001 rolled back toward the open side of the bed and sustained an injury that required transfer to hospital.

PSW #100 failed to ensure resident #001 was safely positioned onto their side. [s. 36.]

***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 safe positioning techniques are utilized for residents that require staff assistance, to be implemented voluntarily.***

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**Ministry of Long-Term  
Care**

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

**Ministère des Soins de longue  
durée**

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

**Issued on this 26th day of May, 2020**

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

**Original report signed by the inspector.**