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
Dec 17, 2020	2020_664602_0022	020963-20, 021120-20, 021754-20, 025069-20	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

WENDY BROWN (602)

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): November 10, 13, 14, 17-20 & 23-27, 2020

The following inspections were conducted
Log #: 020963-20 - regarding sufficient staffing, infection prevention & control practices and personal support services/use of lifts.
Log #: 021120-20 - regarding reporting and complaints, missing items, continence care and activities.
Log #: 021754-20 - regarding alleged improper care and sufficient staffing.
Log #: 025069-20 - regarding visitor protocols.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Directors of Care (ADOC), the Acting Director of Care (DOC), the Infection Prevention & Control (IPAC) management lead, the environmental supervisor, the scheduling coordinator, and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care & progress notes, relevant policies and procedures, investigation documentation, current staffing complements for all shifts and made resident care & service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

4 WN(s)
2 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. 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:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed fully respect and promote resident rights to communicate in confidence, receive visitors of his or her own choice and consult in private without interference as modified by the Ontario COVID-19 Directive #3 for Long-Term Care Homes (LTCH).

The COVID-19 Directive #3 for LTCH states the aim of managing visitors is to "balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life. LTCHs must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies".

The Ontario Ministry of Long-Term Care (MLTC) released COVID-19: LTCH Surveillance Testing and Access to homes. The document identifies caregivers as a type of essential visitor who is designated by the resident and/or their substitute decision-maker (SDM) and is visiting to provide direct care. The directive indicates that homes should adjust their rules for visitors depending on the level of community spread in the region in which the home is located. It outlines that subject to direction of the local public health unit, where the region has not been identified as having higher community spread (grey, red, orange) and the home is not in an outbreak, "a maximum of 2 caregivers per resident may visit at a time".

A resident's designated essential caregiver was advised by the licensee's Infection Prevention and Control (IPAC) management lead that essential caregiver visits are being limited to one caregiver at a time if the caregivers are from different households. The resident has two designated caregivers who live in separate households; both caregivers maintain supportive and meaningful relationships with the resident and would like to visit

the resident together.

The Leeds, Grenville and Lanark District Health Unit (LGLDHU) advised that they have not provided direction to homes related to limiting or restricting essential caregiver visits from specific households.

The essential caregiver's visit request and LGLDHU guidance were reviewed with the licensee's IPAC lead; they advised that the home was not prepared to change their current household specific essential visitor restriction at this time.

The licensee's policy restricts residents from having combined visits from their essential caregivers posing potential harm to the mental, physical and spiritual needs of the resident's quality of life.

Sources: COVID-19 Directive #3-re-issued December 8, 2020, COVID-19: LTCH Surveillance Testing and Access to homes-issued November 23, 2020 & the licensee Checklist for Reviewing Designated Caregiver Plans-Nov. 25/20 and interview(s) with the designated essential caregiver, Administrator, IPAC Management lead, PHN and other staff. [s. 3. (1) 14.]

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 residents rights specific to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, as modified by Directive #3 are fully promoted and respected, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that alleged improper care of a resident was immediately reported to the Director.

A Registered Nurse (RN) complained about the end of life care provided to a resident that may have potentially harmed a resident to the Director of Care (DOC).

The DOC did not alert the Director or complete a Critical Incident report.

Sources: Long Term Care Critical Incident System; resident progress notes; and interviews with an RN, the DOC and other staff [s. 24. (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 alleged improper treatment or care of a resident that resulted in harm or risk of harm to a resident is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to follow their process to report and locate lost resident clothing and personal items.

A resident's family reported multiple personal items were missing from the resident's room. The ADOC searched the unit and located several, but not all of the identified items. The lost and found clothing policy indicates in procedure items:
1) Items reported as lost will be recorded on the missing clothing and/or missing items/glasses dentures and hearing aids form(s) and
3) Label the clothing when it is found. Record the item as being found on the noted forms.
The located and remaining missing items were not recorded on the required form.

Sources: Lost and found clothing policy, missing items form, resident progress notes and interviews with PSWs, the ADOC and other staff. [s. 89. (1) (a) (iv)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that verbal complaint(s) made to the DOC concerning the care of a resident were immediately investigated.

An RN complained about the end of life care provided to a resident to the DOC. The DOC commenced an investigation into the allegations several days later.

Sources: Resident progress notes, email correspondence, and interviews with an RN, the DOC and other staff [s. 101. (1) 1.]

2. The licensee failed to follow up with a complainant regarding their complaint about a verbal interaction with the activation coordinator.

A care conference was held to address multiple issues identified by a resident's Power Of Attorney (POA)/ Substituted Decision Maker (SDM). During this conference the POA/SDM reviewed their concern regarding an interaction they had with the activation coordinator regarding the resident. The DOC intended to investigate the allegation with the activation coordinator, however, the coordinator went on leave prior to a review. The DOC did not follow up with the POA/SDM regarding their complaint citing that they had not yet been able to complete the investigation/resolve the issue.

Sources: Resident progress & care conference notes, complaint intake, and interviews with the DOC and other staff [s. 101. (1) 2.]

Issued on this 18th day of December, 2020

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

Original report signed by the inspector.