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

Ottawa Service Area Office
347 Preston St Suite 420
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Telephone: (613) 569-5602
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347 rue Preston bureau 420
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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
Apr 26, 2021	2021_617148_0014	004778-21	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

AMANDA NIXON (148)

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): March 29, 30, 31 and April 1, 2021

The following intake was completed during this critical incident inspection: Log 004778-21 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant DOC, Clinical Resource Lead, Environmental Manager, Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aids and residents.

The Inspector observed resident care, environment and services including those related to infection control practices. In addition, the Inspector observed bed systems, specifically the use of bed rails and the demonstration of a bed evaluation. Resident health care records were reviewed along with documents related to bed system evaluations.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Nine residents were identified as having one or more bed rails in use. Resident assessments were not completed for any of the nine residents, as required by prevailing practices.

Two residents were involved in an incident of bed entrapment. Neither resident received an immediate assessment, as required by prevailing practices. Both residents were known to have risk factors for entrapment and had other devices applied to the bed system.

One of the residents had a change to the bed system and was experiencing changes in health condition and behaviour leading up to the incident of bed entrapment. The resident’s change in health status and need for bed rails was not assessed as required, to ensure the decision to use bed rails was appropriate.

Additionally, three other residents were provided with new bed systems whereby, bed rail use was changed. The three residents were not provided re-assessment when the type of bed rail was changed. The home has replaced bed systems on four of their resident units, to which it was determined no resident assessments have been completed.

Upon review of resident health care records and discussion with the Director of Care, RAI Coordinator and Environmental Manager, there was no evidence to demonstrate that a resident assessment, including a risk-benefit assessment, had been completed for any resident with bed rails in use.

The failure to ensure that an interdisciplinary resident assessment with risk-benefit assessment was completed, places residents at risk for bed entrapment.

2) The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The bed system of two residents were identified to have failed zone 4 during a bed evaluation in 2020. Steps were not taken to prevent resident entrapment, related to the identified failures, until 2021.

The bed systems of two other residents were identified to have failed zones 3 and 4 in 2020. At the time of this inspection, no steps had been taken to prevent resident entrapment related to the identified failures.

The bed system of a resident had additional devices applied at the time of the resident's entrapment incident. The persons responsible for bed evaluation did not track such changes nor were informed of changes to the bed system. The bed system was then not re-evaluated, as required.

When steps are not taken to address failures or changes of the bed system it places residents at risk for bed entrapment.

The documentation maintained related to bed system evaluations did not include an inventory of all bed systems in use, including bed make and model. Ensuring the maintenance of such information allows for the need for replacement, changes and specific corrective actions to be identified to reduce the risk of entrapment.

Sources: Observations of resident bed systems on the Spruce and Oak Resident Home Areas, interviews with the Environmental Manager, Director of Care and direct care staff and review of resident health care records and the bed system evaluations. Along with the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003), A Guide for Modifying

Bed Systems and Using Accessories to Reduce the Risk of Entrapment (June 2006) and Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability an Other Hazards" (Health Canada, March 2018). [s. 15. (1) (a)]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hand hygiene program was in place in accordance with evidence-based practices, specifically related to assisting residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. On March 30 and March 31, 2021, the meal service observations on the Oak resident home area revealed resident hands were not cleaned before or after the meal. An RPN indicated that the hand sanitizer previously available for use at the entrance/exit to the dining space was removed.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), observation of meal service, interview with an RPN and other staff [s. 229. (9)]

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 there is in place a hand hygiene program in accordance with evidence-based practices, to be implemented voluntarily.

Issued on this 28th day of April, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2021_617148_0014
Log No. / No de registre :	004778-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 26, 2021
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 :	Carolyn Zacharuk

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with O. Regulation 79/10, s.15(1).

Specifically the licensee must:

1) Ensure that all residents who use bed rails, are assessed in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long-Term Care Facilities and Home Care Settings" (Food and Drug Administration, April 2003), to minimize risk to the resident.
This includes but is not limited to:
a) A documented resident assessment, by an interdisciplinary team, that includes identification of risk factors prior to any decision regarding bed rail use or removal from use;
b) A documented risk benefit assessment, by an interdisciplinary team;
c) A documented decision on the use or discontinuation of use of bed rails, by an interdisciplinary team; and
c) Immediate resident assessment after an episode of entrapment.

2) Ensure that all residents who use bed rails have his or her bed system evaluated in accordance with prevailing practices documents, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability an Other Hazards" (Health Canada, March 2018) and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (Food and Drug Administration, June 2006), to minimize risk to the resident.
This includes but is not limited to:
a) Immediate corrective action taken when any bed system does not meet dimensional guidelines; and
b) A documented process to track changes to bed systems and re-evaluated bed systems when changes occur.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Nine residents were identified as having one or more bed rails in use. Resident

assessments were not completed for any of the nine residents, as required by prevailing practices.

Two residents were involved in an incident of bed entrapment. Neither resident received an immediate assessment, as required by prevailing practices. Both residents were known to have risk factors for entrapment and had other devices applied to the bed system.

One of the residents had a change to the bed system and was experiencing changes in health condition and behaviour leading up to the incident of bed entrapment. The resident's change in health status and need for bed rails was not assessed as required, to ensure the decision to use bed rails was appropriate.

Additionally, three other residents were provided with new bed systems whereby, bed rail use was changed. The three residents were not provided re-assessment when the type of bed rail was changed. The home has replaced bed systems on four of their resident units, to which it was determined no resident assessments have been completed.

Upon review of resident health care records and discussion with the Director of Care, RAI Coordinator and Environmental Manager, there was no evidence to demonstrate that a resident assessment, including a risk-benefit assessment, had been completed for any resident with bed rails in use.

The failure to ensure that an interdisciplinary resident assessment with risk-benefit assessment was completed, places residents at risk for bed entrapment.

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and 4 in 2020. At the time of this inspection, no steps had been taken to prevent resident entrapment related to the identified failures.

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Sources: Observations of resident bed systems on the Spruce and Oak Resident Home Areas, interviews with the Environmental Manager, Director of Care and direct care staff and review of resident health care records and the bed system evaluations. Along with the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003), A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (June 2006) and Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability an Other Hazards" (Health Canada, March 2018).

An order was made by taking the following factors into account: Severity: There was actual risk to residents with bed rails in use, as residents are not provided with a resident assessment or bed evaluation, in accordance with prevailing practices. In addition, two incidents of bed entrapment have occurred within the last six months. Scope: The scope of this non-compliance was identified as widespread as it was identified that all residents with bed rails in use have not been provided with a resident assessment, in accordance with prevailing practices. Compliance History: There has been no previous noncompliance to O. Regulation 79/10, s.15 (1) in the past 36 months.
(148)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 26, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 26th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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