Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 18, 26, Sep 23, 2011	2011_048175_0011	Critical Incident

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Registered Nurse, Registered Practical Nurses, Personal Support Worker(s) Assistant Director of Care, Resident Home Area

During the course of the inspection, the inspector(s) Reviewed the health record of identified resident, Critical Incident Report, Procedure Fall Prevention Program #0401-03-78,, Fall Follow-up #0401-03-15, Resident Injury Follow-up #0401-03-16

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A Critical Incident Report was submitted to the Ministry of Health and Long Term Care, indicating an identified resident experienced a fall for which the identified resident was treated in hospital for injuries sustained. Prior to the fall, the resident had an unresponsive spell.

2. An identified Registered Nurse, documented on the resident's Transfer to Hospital Record that the resident had a seizure prior to the fall.

3.An Interdisciplinary Annual Conference indicated the identified resident had 4 unresponsive episodes, at least one, which caused the resident to fall out of bed resulting in injuries.

4.The identified resident's care plan was reviewed post fall and was not revised to include any multi-disciplinary assessment or care interventions related to unresponsive episodes or seizure activity.

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 the resident is re-assessed and the care plan of the identified resident is reviewed and revised at least every six months and at any other time when, the resident's care needs change..., , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

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.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
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. Critical Incident submitted to the Ministry of Health and Long Term Care Ottawa Service Area Office February 7, 2011, reporting an injury to an identified resident January 31, 2011, for which the resident was transferred to hospital.

2. The Assistant Director of Care of the Resident Home Area, said "I completed the Critical Incident, then I filed it with the Ministry. I did not send the Critical Incident Report until February 7, 2011, because of the fracture."

3.The licensee did not ensure that the Director was informed of an injury in respect of which a person is taken to the hospital, no later than 1 business day after the occurrence of the incident, followed by the report required under subsection (4).

Issued on this 13th day of September, 2011

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

L Thompson