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
Mar 23, 2022	2022_873602_0007	014594-21, 016238-21, 018013-21, 018408-21, 018659-21, 020276-21, 020329-21	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

WENDY BROWN (602), 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 7-11, 15, 16 & 21, 2022

Log # 014594-21/CIS # M576-000083-21 - regarding responsive behaviour management,
Log # 016238-21/CIS # M576-000087-21 - regarding alleged staff to resident neglect,
Log # 018013-21/CIS # M576-000092-21 - regarding bed rail use,
Log # 018408-21/CIS # M576-000093-21 - regarding missing controlled substance,
Log # 018659-21/CIS # M576-000096-21 - regarding alleged staff to resident verbal abuse,
Log # 020276-21/CIS # M576-000103-21 - regarding safe transfers, and
Log # 020329-21/CIS # M576-000104-21 - regarding alleged staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with acting Administrator/Director of Care (DOC), the assistant DOC (ADOC)/Infection Prevention and Control (IPAC) lead, an ADOC, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Human Resources Manager, housekeeping and screening staff, a nursing student, residents and family members.

In addition, the inspector(s) reviewed resident health care records, investigation files, bed safety assessment documentation, and made resident care and service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was provided with a safe environment.

A Personal Support Worker (PSW) was repositioning a resident in their bed when the resident hit their head on the bed rail. The PSW was unable to locate the Registered Nurse (RN) to report the injury and asked another PSW to report the incident to registered staff. The incident was not reported. On the following morning the injury was reported to the the RN. An assessment was completed and monitoring was initiated. The subsequent investigation found that the PSW did not report the incident directly to registered staff, putting residents safety at risk in that assessment, treatment and monitoring of the resident's injury was delayed.

SOURCES: Critical Incident (CI) report, investigation file, resident progress notes and plan of care, interviews with the acting Administrator/Director of Care (DOC), acting DOC/Assistant DOC (ADOC) and other staff [s. 5.]

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 a safe and secure environment is provided for their residents, 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 failed to ensure that persons who had reasonable grounds to suspect the neglect of a resident was immediately reported to the Director.

A resident was left on a bedpan for a period of time; during this period the resident was not offered food or fluids for their meal. A Registered Practical Nurse (RPN) and a RN were aware of the incident, however, the incident was not immediately reported to the Director.

Sources: Interviews with the RPN and RN, resident progress notes, and the CI report. [s. 24. (1)]

2. The licensee failed to ensure that persons who had reasonable grounds to suspect the abuse of a resident was immediately reported to the Director.

A resident reported that during care staff had been rough while re-positioning. A RPN and a RN were aware of the resident's report, however, the information was not immediately reported to the Director.

Sources: Interviews with a RPN, written statements from a RPN and RN and the CI report. [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 that persons who have reasonable grounds to suspect abuse and/or neglect of a resident immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: 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 failed to ensure that where bed rails were used, a resident was assessed in accordance with prevailing practices, to minimize the risk to the resident.

The following is further evidence to support a compliance order.

A resident had a fall from bed and was found between the mattress and bed rail. The resident's bed safety assessment included the identification of risks, however, the assessment failed to include a risk benefit assessment and the decision to continue the use of bed rails was not completed in accordance with the Clinical Guidance document, which may have placed the resident at risk for bed entrapment.

A follow up inspection to the compliance order determined compliance with O.Reg 79/10 s.15.

Sources: Resident Bed Safety Assessment and progress notes. [s. 15. (1) (a)]

Issued on this 24th day of March, 2022

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

Original report signed by the inspector.