Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: April 14, 2023

Inspection Number: 2023-1584-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott

Long Term Care Home and City: St. Lawrence Lodge, Brockville

Lead Inspector	**Inspector Digital Signature**
Ashley Bernard-Demers (740787)	Ashley F Bernard -Demers Digitally signed by Ashley F Bernard-Demers Date: 2023.04.24 10:57:27 -04'00'

Additional Inspector(s)
Kayla Debois (740792)
Cheryl Leach (719340)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 22-24, 27-31 and April 3-5, 2023

The following intake(s) were inspected:

Intake: #00001806 - [CI: M576-000050-22]
Intake: #00005329 - Complaint about skin and wound care for a resident
Intake: #00005625 - [CI: M576-000045-22] Fall of resident with injury
Intake: #00008001 - IL-05509-AH/M576-000053-22 and Intake: #00008247-M576-000054-22 - Resident injuries of unknown etiology
Intake: #00016552 - M576-000063-22 Improper/incompetent care of resident resulting in transfer to hospital
Intake: #00018073 - IL-09146-AH/M576-000003-23 Staff to resident alleged abuse
Intake: #00018194 - M576-000004-23 Resident to resident physical alleged abuse
Intake: #00019243 - Complainant reports lack of wound care
Intake: #00022204 - Medical care completed without POA's consent

The following intakes were completed in this inspection: Intake #00001941, CI#M576-000043-22;

Intake #00007142, CI#M576-000052-22; Intake #00012845, CI#M576-000058-22; Intake #00013446, CI#M576-000059-22; Intake #00021504, CI#M576-000008-23 were related to falls.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of a resident's plan of care.

Rationale and Summary
Inspector #740787 reviewed an email from a resident's substitute decision maker (SDM) to Administrator #130 and Assistant Director of Care (ADOC) #105, regarding a request to cease completion of a medical treatment.

DOC #104 stated that medical treatment was attempted for the resident, despite the resident's SDM requesting that it no longer be completed.

Failing to involve a resident's substitute decision-maker, or any other persons designated by the resident or substitute decision-maker in the opportunity to participate fully in the development and implementation of the resident's plan of care places the resident at risk for receiving medical treatments

for which consent has not been given.

Sources:
Interview with DOC #104, review of email to the home from resident's SDM
[740787]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding abuse of a resident.

Rationale and Summary
A review of the critical incident report noted that the alleged incident of resident abuse was not reported to the Director immediately.

In an interview with Assistant Director of Care #116 they confirmed that the incident was not immediately reported to the Director.

Failing to immediately report all allegations of resident abuse and neglect to the Director, places residents at risk of harm.

Sources: Critical Incident Report, and interview with ADOC #116
[740787]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their falls prevention and management policy and procedure is complied with.

Specifically, staff did not comply with their post fall monitoring head injury routine procedure: to monitor for indications of impending problems following a head injury in order to ensure prompt and appropriate intervention. Registered staff will perform assessment protocol, including vital signs, pupil response, level of consciousness, and orientation to person, place and time. The procedure and purpose will be explained to the resident and/or family and unless otherwise ordered by a physician will be

instituted as follows:
-Q 15 minutes x2. If stable then -
-Q 30 minutes x2. If stable then -
-Q 60 minutes x2. If stable then -
-Q shift x 3 days

Rationale and summary:
A resident had an unwitnessed fall with injury. A Head Injury Monitoring tool was not completed during a night shift.

Registered Nurse (RN) #107 confirmed that if the assessment was not documented on the paper copy or PointClickCare (PCC), then it was not done. Assistant Director of Care (ADOC) #105 confirmed that it is the expectation that the Head Injury Monitoring tool is completed in full.

As a result, there was a risk that prompt interventions following a head injury would not have been addressed in the absence of monitoring tool information.

Sources:
Resident progress notes, electronic & hard copy chart review, Procedure for Head Injury Routine - #0401-05-56 - issued March 2003; interviews with RN #107 and ADOC #105.
[740792]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 10.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is access to hand hygiene agents including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
It was observed that several Isagel hand sanitizers in circulation throughout the home had an alcohol content of 60%.

In an interview with IPAC lead #102 they indicated that the manufacturer had changed the alcohol percentage in the hand sanitizer to 60% and did not update the home.

The use of expired hand sanitizer increases the risk of transmission of infectious agents.

Sources: Interview with IPAC lead #102, and observations by Inspector #740787.
[740787]