

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

	Original Public Report
Report Issue Date: December 14, 2023	
Inspection Number: 2023-1584-0006	
Inspection Type:	
Complaint	
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
Marko Punzalan (742406)	
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27, 28, 29, 2023, and December 5, 6, 7, 8, 2023

The following intake(s) were inspected:

- Intake: #00100837 Complaint regarding home staff not identifying and responding promptly to a resident's decline in health status.
- Intake: #00101993 Complaint regarding the general condition of the home for staff and residents.



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

Resident Care and Support Services Infection Prevention and Control

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 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

Rationale and Summary:

On an identified date in September 2023, the resident's physician ordered weekly blood work for CBC, ESR, and CRP. A review of the resident's health records revealed that weekly blood work was not done during the specific week in October 2023.

Interview with Registered Nurse (RN) that blood work should have been done during a specific week in October 2023.



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Failing to ensure the completion of blood work, set out in the plan of care could result in delayed treatment for the resident.

Sources: resident's health care records and interview with RN.

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