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: September 20, 2024
Inspection Number: 2024-1584-0003
Inspection Type: Critical Incident
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10, 11, 12, 13, 16, 17, 18, 2024

The following intake(s) were inspected:

- Intake: #00119557-CIR M576-000027-24, Intake: #00121154-CIR M576-000032-24, Intake: #00121542-CIR M576-000033-24, Intake: #00122658-CIR M576-000040-24, Intake: #00123007-CIR M576-000043-24-Alleged resident to resident physical abuse.
- Intake: #00121943-CIR M576-000035-24-Alleged resident to resident physical and sexual abuse.
- Intake: #00122388-CIR M576-000037-24-Alleged resident to resident physical and verbal abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, by anyone, that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

In July 2024, an incident of physical abuse between two residents was not reported to the Director.
In July 2024, an incident of physical abuse between two residents was reported to the Director one day later.

Sources: Residents' health care records and an interview with a Registered Nurse (RN) and the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident who had physical responsive behaviours, had hourly behaviour monitoring assessment documentation completed.

Sources: Resident's health care records and an interview with an RN and the Director of Care (DOC).

The licensee has failed to ensure that a resident who had physical responsive behaviours, had hourly DOS (Dementia Observation System) behaviour monitoring documentation completed.

Sources: Resident 's health records and an interview with the ADOC.