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

Public Report

Report Issue Date: May 23, 2025

Inspection Number: 2025-1584-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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): May 1, 2, 5-9, 13-16, and 20, 2025.
The following intake(s) were inspected:

- Intake: #00139668/ CIS #M576-000029-25- regarding a resident injury from an unknown cause.
- Intake: #00140788 - Compliance order follow-up - WS-2025-1584 O. Reg. 246/22 - s. 140 (1)
- Intake: #00143314 - CIS #M576-000051-25 -regarding alleged resident to resident physical abuse.
- Intake: #00144026 - CIS #M576-000056-25 – regarding alleged staff to resident verbal abuse.
- Intake: #00144274 - Complaint regarding improper care and alleged neglect.
- Intake: #00144446 - CIS #M576-000057-25- regarding alleged resident to resident physical abuse.
- Intake: #00145194 - Complaint regarding lack of recreational activities for residents.
- Intake: #00145694 - CIS #M576-000067-25 – regarding alleged staff to resident verbal/emotional abuse.
- Intake: #00145705 - CIS #M576-000068-25 – regarding alleged staff to resident verbal/emotional abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1584-0001 related to O. Reg. 246/22, s. 140 (1)

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Recreational and Social Activities
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 6.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The licensee has failed to ensure a resident's condition was reassessed and the effectiveness of the restraining specific to the use of a seatbelt was evaluated by a member of the registered nursing staff at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances during a three month period.

Sources:
Interviews with Quality Improvement Lead (QIL), and registered staff and reviews of the Restraints and PASDs policy and procedure and related electronic Treatment Administration Records (eTAR) and Medication Administration Records (eMAR).

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that all assessments related to the use of a physical device to restrain a resident was documented. Specifically the completion of the initial restraint assessment when a seatbelt for restraining purposes was implemented for a resident.

Sources:

Interviews with QIL, and registered staff and reviews of the Restraints and PASDs policy and procedure and related Point Click Care assessment documentation.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Review and evaluate the effectiveness of the licensee's current zero tolerance of abuse and neglect training, specifically related to abuse definitions and immediate reporting requirements, and determine if including case studies of abuse such as this/or similar incident, would enhance the awareness and learning of staff. Consider also including reporting scenarios that may impair immediate reporting. Keep a written record of the evaluation.

2) Provide face to face re-education to all personal support workers (PSWs) and registered nursing staff on the homes abuse/neglect policy including the definitions of abuse, and immediate reporting requirements. Maintain a written record of the names of all PSW and nursing staff who received training including the date the training was received.

3) On a weekly basis, review all resident abuse/neglect Critical Incidents for a two month period. Take remedial action if reporting is not completed as per legislation

and keep a written record of the remedial action.

Grounds

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the Abuse and Neglect of Residents Policy requires that witnesses to abuse immediately report their findings to registered staff, a manager and/or the manager on call.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the Abuse and Neglect of Residents Policy requires that witnesses to abuse immediately report their findings to registered staff, a manager and/or the manager on call.

1. On a specified date, a Personal Support Worker (PSW) failed to immediately report a witnessed incident of suspected staff to resident verbal/emotional abuse. The Critical Incident (CI) report indicated that the PSW was uncomfortable with the way another PSW was speaking with a resident, and their treatment of the resident's belongings while in the tub room. The PSW reported the incident to the Assistant Director of Care (ADOC) six days later.

2. On another date, a Registered Practical Nurse (RPN) failed to immediately report an alleged incident of resident to resident abuse to their supervisory staff. The RPN reported the incident two days later; this delay put residents at risk as the resident involved was not closely monitored.

3. On a subsequent date, two PSWs failed to immediately report a witnessed incident of alleged staff to resident verbal/emotional abuse. The CI report indicates that a PSW was assisting a resident with their morning care when two additional PSWs entered the room. One of the PSWs started speaking with the resident in a loud and aggressive way resulting in the resident becoming resistive to care; the resident attempted to strike staff who had to exit the room prior to the completion of

am. care.

In a subsequent incident, on the same day, a PSW was assisting a resident with toileting when a PSW entered the bathroom and yelled at the resident causing them to hit and attempt to bite the PSW. Following this incident, a PSW provided emotional support to the resident as they were crying and asking for their family.

The two PSWs who witnessed the incidents notified their ADOC via separate emails one day following the incidents. The emails were not reviewed until two days after the incidents.

Failure to report the witnessed abuse placed multiple residents at risk of further abuse.

Sources:
Review of CI reports: #M576-000056-25, #M576-000057-25, #M576-000067-25 and #M576-000067-25, and the Abuse and Neglect of Residents Policy, and interviews with three ADOCs, two PSWs, one resident and other staff.

This order must be complied with by
August 22, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO under FLTCHA, s. 25 (1) was issued #2024-1584-0004 on November 14, 2024 and was complied.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.