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: July 24, 2025

Inspection Number: 2025-1584-0006

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): July 8, 9, 10, 14, 15, 16, 17, 18, 22, 23, 2025

The following intake(s) were inspected:

- Intake: #00144360-CIR-M576-000060-25 and Intake: #00148571-CIR-M576-000092-25-Improper/Incompetent care of a resident by staff.
- Intake: #00146830-CIR-M576-000078-25-Hypoglycemic incident for a resident resulting in a transfer to hospital.
- Intake: #00147105-Complaint with concerns regarding responsive behaviours.
- Intake: #00147896-CIR-M576-000087-25-Resident to resident physical abuse.
- Intake: #00149602-Complaint with concerns regarding fall prevention and restraints.

- Intake: #00149632-CIR-M576-000099-25 and Intake: #00150460-CIR-M576-000109-25-Fall of resident resulting in an injury and transfer to hospital.
- Intake: #00150483-Follow-up #: 1-FLTCA, 2021-s. 5, Safe and Secure Home-CDD-July 18, 2025.
- Intake: #00150484-Follow-up #: 2-O. Reg. 246/22-s. 12 (1) 3, Doors in a Home-CDD-July 18, 2025.
- Intake: #00150723-CIR-M576-000112-25 and Intake: #00151333-CIR-M576-000120-25-Allegation of resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1584-0004 related to FLTCA, 2021, s. 5
Order #002 from Inspection #2025-1584-0004 related to O. Reg. 246/22, s. 12 (1) 3.

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

Resident Care and Support Services
Medication Management
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care specific to toileting a resident was documented on multiple dates from March to June 2025.

Sources: Interview with Assistant Director of Care (ADOC), a Personal Support Worker (PSW), Point of Care (POC) documentation for March, April, May, June 2025, Point Click Care (PCC) care plan.

WRITTEN NOTIFICATION: Duty to Protect-Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the

health, safety or well-being of one or more residents."

The licensee has failed to ensure that a resident was not neglected by the licensee or staff. A resident's plan of care indicated that they required staff assistance for personal care on day and evening shifts and that they were to be toileted including continence care every AM, after meals, PM, HS and overnight. Specifically, on a specific date in June 2025, the resident was not assisted with personal care or toileted including continence care at HS as per their plan of care.

Sources: Resident's health care records, the home's investigation file, nursing schedule and interviews with the ADOC, the Human Resources Director, a Registered Practical Nurse (RPN) and PSW's.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

This licensee has failed to inform a complainant that a written complaint that they

submitted in May 2025 could not be investigated and resolved within 10 business day, and the complainant was not provided with a reasonably expected date of resolution.

Sources: Interview with the Administrator, Critical Incident Reports (CIR).

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.
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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee has failed to ensure that staff applied a physical device to a resident that had been ordered or approved by a physician or registered nurse in the extended class. A Registered Practical Nurse initiated a restraint for a resident in April 2025 without a physician's order. The physician did not approve the restraint until several days later.

Sources: resident health care record; Restraints and PASDs Policy; Order Summary Report; and interviews with an RPN and the the Director of Care (DOC).

WRITTEN NOTIFICATION: Restraints Monitoring

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 3.
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:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

The licensee has failed to ensure that on a specific date in June 2025, a resident's restraint was monitored every hour as per the home's Restraint and PASD Policy.

Sources: resident's health care records, Restraints and PASDs Policy, the home's investigation file, nursing schedule and interviews with an ADOC, an RPN and PSW's.

WRITTEN NOTIFICATION: Restraints Release and Repositioning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.
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:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

The licensee has failed to ensure that on a specific date in June 2025, the release of the restraint and repositioning of a resident was completed every 2 hours as per the home's Restraint and PASD Policy.

Sources: resident's health care records, Restraints and PASDs Policy, the home's investigation file, nursing schedule and interviews with an ADOC, an RPN and PSW's.

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #007 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 the monitoring of a resident's physical restraint device was documented. Specifically, on multiple dates in April and July, 2025, the hourly monitoring of the resident's restraint was not documented.

Sources: resident's health care record; Restraints and PASDs Policy; and an interview with the DOC.

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 7.

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:
7. Every release of the device and all repositioning.

The licensee has failed to ensure that the repositioning of a resident, who used a physical restraint device, was documented. Specifically, on multiple dates in April and July, 2025, two hour repositioning of the resident, who used a restraint, was not documented.

Sources: resident's health care record; Restraints and PASDs Policy; and an interview with the DOC.

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg.

66/23, s. 30.

The licensee has failed to ensure that the Medical Director and the pharmacy service provider were notified when a resident experienced an incident of severe hypoglycemia and was administered glucagon.

Sources: Resident's health care record; CIR; and interviews with the DOC, the Medical Director and a Pharmacist.

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee has failed to ensure that when a resident experienced an incident of severe hypoglycemia and administration of glucagon, a medication incident report was completed and the incident reviewed, and analyzed.

Sources: Resident's health care record; Glucagon Protocol; interview with ADOC's, and the Quality Improvement Lead.

COMPLIANCE ORDER CO #001 Plan of care

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Ensure that residents who have a specific falls prevention and management intervention device in their plan of care, as part of the Falls Prevention and Management Program, have this device in place, turned on, and in good working order.
B) Complete audits for residents who have a specific falls prevention and management device in their plan of care, as part of the Falls Prevention and Management Program, to ensure that this device is in place, turned on, and in good working order.
C) The audits required in (B) are to occur on one day shift and one evening shift each week, for a period of four weeks. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings, and any corrective actions taken.

Grounds

The licensee has failed to provide a resident with toileting as set out in their plan of care on a specific date in June 2025.

Sources: Interview with an ADOC, Point of Care (POC) documentation for June 2025, resident's Point Click Care-care plan.

The licensee has failed to ensure that the care set out in a resident plan of care was provided as specified in their plan. Specifically, a resident was to have a falls prevention and management intervention device applied, be turned on, and in working order. The resident experienced a fall and subsequently was transferred to hospital. Staff responded to the resident's calls for help and noted the falls prevention and management intervention device was not working. Furthermore, the next day, another staff member entered the resident's room and noted the falls prevention and management intervention device was turned off.

Sources: resident's health care record; investigation notes; and interviews with a Registered Nurse (RN), RPN's, and the DOC.

The licensee has failed to ensure that the care set out in another resident's plan of care was provided as specified in their plan. Specifically, the resident was to have a falls prevention and management intervention device applied, be turned on, and in working order. The resident was found in the dining room after staff heard a thump. The falls prevention and management intervention device was turned off.

Sources: resident's health care record; Risk Management Incident Report; CIR; and interviews with a PSW, an RPN, and the DOC.

This order must be complied with by September 18, 2025

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

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.