

**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:** January 15, 2026

**Inspection Number:** 2025-1584-0008

**Inspection Type:**

Complaint  
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**

This inspection occurred onsite on the following dates: December 30, 31, 2025, January 6-9, 2026, January 12-14, 2026.

The following intakes were completed in this Critical Incident (CI) inspection: Intake #00162328/CI#M576-000184-25 and Intake #00162659/CI#M576-000185-25 regarding falls that resulted in significant changes in status.

The following intakes were completed in this complaint inspection: Intake #00163688 regarding allegation of neglect, and staffing concerns. Intake #00165172 regarding concerns related to fall prevention and management and catheter care.

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

- Contenance Care
- Skin and Wound Prevention and Management

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Medication Management  
Prevention of Abuse and Neglect  
Staffing, Training and Care Standards  
Reporting and Complaints  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

#### **Non-compliance with: FLTCA, 2021, s. 6 (5)**

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specific day the restorative nursing toileting program was discontinued for a specific resident. However the resident's substitute decision maker (SDM) was not given the opportunity to participate in the decision to discontinue the program.

Sources: Interview with a Associate Director of Care, a Quality Improvement Lead, resident's SDM, a Personal Support Worker, resident's health care record.

### WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A specific resident returned from the hospital on a specific day, with a dressing over a specific type of wound. Instructions indicated the dressing was to remain in place for 14 days therefore no Skin and Wound Assessment was completed. When the dressing was first removed on the specific day, as per a new order, a Skin and Wound Assessment was not completed. The first assessment with a clinically appropriate Skin and Wound Assessment tool was not completed until seven days later.

Sources: the Resident's medical record, interviews with two specific Registered Nurses, a Registered Practical Nurse RPN, and an ADOC.

**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) 1.**

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:

1. The complaint shall be investigated and resolved where possible, and a response

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that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

On a specific day the substitute decision-maker (SDM) for a specific resident submitted concerns via email to an Administrator, a Director of Care (DOC), and an Associate Director of Care. The concerns were related to the process for required documentation when hiring external care providers and the toileting schedule for a specific resident . A response addressing the documentation process for hiring an external care provider was provided to the SDM on a specific day. However, no response was given regarding the concerns about the toileting plan for resident the resident.

Sources: Interview with an Administrator, a Director of Care, an Associated Director of Care, a Personal Support Worker, resident's SDM, email sent on a specific day

## **WRITTEN NOTIFICATION: Administration of drugs**

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### **Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

On a specific day a medication was ordered for a resident by a physician for a specific health condition. A review of the electronic medication administration record (eMAR) indicated that the resident did not receive the medication as ordered

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by the physician until multiple days after the order was received.

Sources: Interview with an Associate Director of Care, physician's orders, electronic medication record (eMAR), resident's progress notes.