



**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch  
Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ème</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 21, 22, 24, 2011	2011_042148_0011	Critical Incident

**Licensee/Titulaire de permis**

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott  
c/o St. Lawrence Lodge, 1803 County Road 2, BROCKVILLE, ON, K6V-5T1

**Long-Term Care Home/Foyer de soins de longue durée**

ST. LAWRENCE LODGE  
1803 County Road, #2 East, Postal Bag #1130, BROCKVILLE, ON, K6V-5T1

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

AMANDA NIXON (148)

**Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nursing Staff, Personal Support Workers and residents on the 3rd floor units.

During the course of the inspection, the inspector(s) reviewed the home's investigation notes, resident health records and the home's Abuse and Neglect of Residents Policy (#0202-02-05) and the Investigation of Resident Abuse and/or Neglect Procedure (# 0202-02-06).

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

Definitions

WN – Written Notification  
VPC – Voluntary Plan of Correction  
DR – Director Referral  
CO – Compliance Order  
WAO – Work and Activity Order

Définitions

WN – Avis écrit  
VPC – Plan de redressement volontaire  
DR – Aiguillage au directeur  
CO – Ordre de conformité  
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**  
**Specifically failed to comply with the following subsections:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).**

**Findings/Faits sayants :**

1. The home's Investigation of Resident Abuse and/or Neglect Procedure (# 0202-02-06) indicates that " Any employee who witnesses or suspects abuse or neglect of a resident by another employee must report the incident to his/her Manager/delegate immediately" .
2. Interview on June 22, 2011, with the Director of Care, stated that during the weekends the delegate (as per the Abuse policy) is the Registered Nursing Staff on duty.
3. An incident of alleged staff to resident abuse occurred on Sunday, June 12, 2011. On June 13, 2011 at 1430 hours, a Personal Support Worker reported the alleged abuse to the unit's Assistant Director of Care. The Personal Support Worker did not immediately report the incident to the Manager/delegate on June 12, 2011.

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following subsections:**

**s. 24. (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:**

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

**Findings/Faits sayants :**

1. An incident of alleged staff to resident abuse occurred on Sunday, June 12, 2011. On June 13, 2011 at 1430 hours, a Personal Support Worker reported the alleged abuse to the unit's Assistant Director of Care.
2. The Director was informed of the incident of alleged abuse on the afternoon of June 13, 2011. The Director was not immediately informed of the incident of alleged abuse. [s. 24(1)2.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**  
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

- (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
- (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
- (c) identifies measures and strategies to prevent abuse and neglect;
- (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
- (e) identifies the training and retraining requirements for all staff, including,
  - (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
  - (ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

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**Findings/Faits sayants :**

1. The home's Abuse and Neglect of Residents Policy (#0202-02-05) and the Investigation of Resident Abuse and/or Neglect Procedure (#0202-02-06), does not identify the training and retraining requirements for staff including the power imbalances between staff and residents, and situations that may lead to abuse. [O.Reg79/10,s. 96(e)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following subsections:**

- s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
- (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
  - (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

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**Findings/Faits sayants :**

1. An incident of alleged staff to resident abuse occurred on Sunday, June 12, 2011. On June 13, 2011 at 1430 hours, a Personal Support Worker reported the alleged abuse to the unit's Assistant Director of Care.
2. Resident Substitute Decision Maker's were not notified of the alleged abuse until June 14, 2011. [s.97(1)(b)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits sayants :**

1. An incident of alleged staff to resident abuse occurred on Sunday, June 12, 2011. On June 13, 2011 at 1430 hours, a Personal Support Worker reported the alleged abuse to the unit's Assistant Director of Care.
2. The police force was notified of the alleged abuse on June 13, 2011. The police force was not immediately notified of the incident of alleged abuse.



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the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
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**Rapport d'inspection  
prévus le Loi de 2007 les  
foyers de soins de longue**

Issued on this 24th day of June, 2011

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**