



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Public Copy/Copie du public

| Report Date(s) / Date(s) du rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|--|---|-----------------------------------|--|
| Aug 16, 2017 | 2017_664602_0022 | 014261-17 | Complaint |

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 24 & 25, 2017

Complaint log# 014261-17 concerning multiple issues specific to the plan of care.

During the course of the inspection, the inspector(s) spoke with the resident, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses, the Assistant Director of Care (ADOC), and the Director of Care

**The following Inspection Protocols were used during this inspection:
Contenance Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.

Plan of care

Specifically failed to comply with the following:

- s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
 - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
 - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**



Findings/Faits saillants :

1. The licensee has failed to ensure that their written plan of care provides clear directions to staff and others who provide direct care to the resident.

On a specified date a complainant advised they had been told that a resident required specific treatments and related interventions and they were unsure as to whether the resident is receiving the required treatments and interventions

A review of the current care plan in the unit's care plan binder and the electronic record, indicated that the resident required a specific treatment. The hard copy treatment administration record (TAR) indicated that the treatment is no longer required; this was confirmed with nursing staff and in a MDS assessment. The ADOC explained that if there is conflicting written and verbal information specific to a resident's care the most up to date information can be obtained in the unit's care plan binder and that any interventions in the care plan should match those found in the TAR and the electronic plan of care.

The home failed to ensure the written plan of care provides clear direction to staff and others as hard copy and electronic information indicate that resident #001 requires a specific treatment, and this is contrary to interview and current treatment administration documentation which indicate the treatment is no longer required.

The licensee has failed to ensure that their written plan of care provides clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

Issued on this 17th day of August, 2017

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



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Original report signed by the inspector.