Ontario

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 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2019	2019_505103_0028	017300-19, 018099-19, 019847-19	Critical Incident System

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 21-23, 2019.

The following intakes were inspected:
Log #017300-19 (CIS #M576-000018-19), Log #018099-19 (CIS #M576-000019-19) and

Log #019847-19 (CIS #M576-000020-19)-incidents that caused an injury to a resident for which the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), a Physiotherapy Aide, the Coordinator of Activation/Volunteer Services and the Director of Care (DOC).

During the course of the inspection, the inspector reviewed resident health care records, the Critical Incident Reports related to these intakes, made resident observations and reviewed the Licensee's policy, "Minimal lift policy, #0404-03-09", which was last reviewed November 2017.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure staff used safe transferring techniques when assisting resident #002.

On an identified date, resident #002 was being transferred with the assist of a mechanical lift from their wheelchair back into bed. During the transfer, resident #002 fell out of the sling onto floor and sustained identified injuries.

PSW's #104 and #105 were present during the fall and both were interviewed separately. The PSW's indicated that during the transfer with the mechanical lift, the resident was observed to be having a bowel movement. PSW #104 stepped away from the transfer to retrieve supplies and during that time, resident #002 fell out of the sling and onto the floor. PSW #104 indicated they should not have stepped away from the resident while they were in the process of being transferred into bed. Both PSW's also indicated they failed to do a visual check prior to the lift.

DOC #103 was interviewed and stated all mechanical lift transfers require two staff to be present from start to finish and the lift policy requires staff to complete a visual check prior to the lift to ensure the resident's safety. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #002 is safely transferred by mechanical lift in accordance with the Licensee's policy, "Minimal lift policy, #0404-03-09", to be implemented voluntarily.

Issued on this 28th day of October, 2019

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

Original report signed by the inspector.