Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Aug 9, 2021	2021_593573_0015	006503-21, 007715-21, 007740-21, 007879-21, 008146-21, 008514-21, 008515-21, 008517-21, 008541-21, 008570-21, 008607-21, 008680-21, 009131-21, 010548-21	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

ANANDRAJ NATARAJAN (573), EMILY PRIOR (732), MARK MCGILL (733)

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): June 28, 2021 – July 02, 2021 and July 05 – 09, 2021.

The Following logs were completed in this Critical Incident System (CIS) inspection:
(i) Log #008515-21, Log #008680-21, and Log #009131-21, were related to resident's medication incident.
(ii) Log #006503-21 and Log #008541-21 were related to staff to resident alleged abuse and neglect.
(iii) Log #007879-21 related to improper/incompetent treatment of a resident that results in harm or risk to a resident.
(iv) Log #008607-21 related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
(v) Log #010548-21 regarding a fall incident that caused injury to a resident.

During the course of the inspection, the inspector(s) spoke with the residents, Housekeeping Aide, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Directors of Care (ADOCs), the Quality assurance and Project lead, the Environmental supervisor, the Director of Support Services, the Infection Prevention & Control (IPAC) Lead and the Director of Care (DOC).

During the course of the inspection, the inspector(s) reviewed the resident health care records, and other pertinent documents. The Inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
6 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 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 the written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident

A review of the plan of care for three specific residents indicated that all required some level of assistance with toileting. Frequency or times of continence checks/continence product changes however was not indicated.

It was not documented in any location when residents are to be toileted and/or changed out of their continence products. Instead, as per the PSWs, staff are required to create their own system of managing toileting and continence care. By doing this, toileting opportunities may be missed which can lead to an increased risk of skin breakdown and other health concerns.

Sources: Interviews with the PSWs, record review. [s. 6. (1) (c)]

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 the written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Safe Medication Administration procedure was complied with.

Under O.Reg 79/10 s.114(2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home and O.Reg 79/10 s.8(1)(b) specifies that they must be complied with.

St. Lawrence Lodge Procedure 0401-02-34: Safe Medication Administration described that following identification of the resident, administer the medication to the resident ensuring it has been ingested. Initial the Medication Administration Record (MAR) in the appropriate location. If dose is not administered make notation in the appropriate space.

A Medication Incident Report (MIR) was filed for the omission of a resident’s medication, as the medication had not been documented as given in the MAR. When the RPN who was alleged to have missed giving the resident’s medications was interviewed, they explained that they had given the resident’s medication but that they had forgotten to document it in the MAR.

There is risk to resident safety when procedures are not complied with.

Sources: The Medication Incident Report (MIR), St. Lawrence Lodge Procedure 0401-02-34: Safe Medication Administration; and interview with the RPN and other staff. [s. 8. (1)(b)]

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 that the Safe Medication Administration procedure was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature of at least two resident bedrooms in different parts of the home and one resident common area on every floor, was measured and documented and that the measured temperature was documented at least once every morning, once every afternoon, and once every evening or night.

The inspector spoke with the Quality Assurance and Project Lead, who stated that the staff monitor air temperature in three resident rooms in different parts of the home, but the temperatures were not documented. Furthermore, they confirmed that the resident common area on the floors, were not measured and documented. When steps are not taken to measure and document the air temperatures in the specified areas of the home during the required time frames it places risk to the resident comfort and safety.

Sources: Memo for the Assistant Deputy Minister, Long-Term Care Operations Division to Long-Term Care Home Stakeholders, April 1, 2021; and interview with Quality assurance and Project Lead. [s. 21. (3)]

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 that the temperature is measured and documented in at least two resident bedrooms in different parts of the home, one resident common area on every floor, and every designated cooling area at least once every morning, once every afternoon, and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that the medication cart remained locked at all times when not in use.

Inspector observed two RPN’s handing out medications on separate units. Both RPN’s prepared their medications at the medication cart, then left the medication cart to administer the medications to the resident. The medication cart was not locked when the RPN’s stepped away to administer the medications.

The DOC explained that the medication cart should be locked when not in use and the expectation is that staff lock the cart during their medication pass, any time they step away from it. An internal email was also sent to all registered staff and ADOC’s that described that it is imperative to keep all medication carts locked between medication administration to the residents and if the cart is left for any reason, it must be locked.

When the medication cart is not locked, there is risk to resident safety as residents may be able to access the medications within it.

Sources: Day Force memo; interview with the DOC; and medication administration observations. [s. 130. 1.]

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 that the medication cart remained locked at all times when not in use, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents were given medication as prescribed.

Two residents were not administered with their specified medication as per the prescriber. The RPNs assigned to the residents confirmed that the medication was not given to the residents. Although neither resident suffered ill effect from the medication incidents, there was potential risk of harm to the residents, since the medications were not given as prescribed.

Sources: Medication Incident Reports; the Medication Administration Records, interview with the RPNs and other staff [s. 131. (2)]

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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to the use of the eye protection.

According to the Chief Medical Office of health (CMOH) Directive #3 for Long-Term Care Homes (June 4, 2021), Effective Date of Implementation: June 9, 2021 and the COVID-19 guidance document for long-term care homes in Ontario. All staff and essential caregivers are required to wear appropriate eye protection (for example, goggles or face shield) when unable to maintain two meters of physical distancing, such as when they are providing direct care or interacting with the residents when indoors.

During an observation of three specific residents' units, the inspector observed registered and non-registered staff providing direct care, within two metres of the residents were not wearing their eye protection. The failure to follow the infection prevention and control practices posed an infection control risk to the residents.

Sources: Direct observation, Infection Prevention and Control Program lead and other staff interviews [s. 229. (4)]

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 that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The following is further evidence to support the order issued on July 13, 2021 (A1), during inspection 2021_617148_0014 (A1) to be complied by August 16, 2021 (A1).

A Critical incident Report (CIR) indicated that a resident was involved in an incident of bed rail entrapment. The inspector reviewed the resident's health care records, which indicated that bed rails were in use since the resident's admission to the home. Furthermore, upon review of the health care records there was no evidence to demonstrate that a resident assessment in accordance with prevailing practices related to the use of bed rails, had been completed prior to the incident. [s. 15. (1) (a)]

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The bed system of a resident, where bed rails were in use, were identified to have failed entrapment zone 4. Steps were not taken to prevent resident entrapment, related to the identified failed zone, until the resident was involved in an incident of bed rail entrapment. When steps are not taken to address the failure of the potential zone of entrapment it places the resident at risk for bed entrapment.

Sources: Review of the Critical incident Report (CIR) , resident's health care records, interviews with the Environmental Supervisor and the Director of Care. [s. 15. (1) (b)]

Issued on this 10th day of August, 2021

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

Original report signed by the inspector.