

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
Mar 22, 2022	2022_873602_0008	000181-22, 001480- 22, 001658-22, 003836-22	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), AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 7-11, 15 & 16, 2022

Log # 000181-22 regarding multiple care and communication concerns.

Log # 001480-22 regarding bed rail use, care planning and fall risk.

Log # 001658-22 regarding responsive behavior management.

Log # 003836-22 regarding bed rail use and fall risk.

During the course of the inspection, the inspector(s) spoke with the acting Administrator/Director of Care (DOC), the assistant DOC (ADOC)/Infection Prevention and Control (IPAC) lead, an ADOC, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Human Resources Manager, housekeeping and screening staff, a nursing student, residents and family members.

In addition, the inspector(s) reviewed resident health care records, investigation files, risk management, call bell and temperature monitoring reports, and made resident care and service and IPAC practice observations.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care for a resident, related to falls prevention and management, was provided as set out by the plan of care.

The plan of care described that a resident was to be provided with a bed alarm while in bed. The resident was found by staff during rounds to have fallen out of bed. It was discovered, that at the time of the fall, that the bed alarm was not functional and did not sound at the resident's movement out of bed.

The non functioning bed alarm lead to staff not being immediately notified of the resident's movement from bed.

Sources: Risk Management Report for the fall, the plan of care for the resident and an interview with a RN [s. 6. (7)]

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 care set out in the plan of care is provided, to be implemented voluntarily.

Issued on this 23rd day of March, 2022

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

Original report signed by the inspector.