Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 9, 2024

Inspection Number: 2024-1584-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott

Long Term Care Home and City: St. Lawrence Lodge, Brockville

Lead Inspector	**Inspector Digital Signature**
Gabriella Kuilder (000726)	Gabriella Kuilder Digitally signed by Gabriella Kuilder Date: 2024.05.17 14:08:42 -04'00'

Additional Inspector(s)
Cheryl Leach (719340)
Polly Gray-Pattemore (740790)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 10, 11, 12, 15, 16, 18, 19, 22, 23, 24, 25, 2024.

The following intakes were completed in this complaint inspection:

- Intake: #00100222 was related to the management of responsive behaviours for a resident.
- Intake: #00112971 was related to management of a resident's personal care, responsive behaviours, and safety equipment.
- Intake: #00110452 - was related to medication administration for a resident.

The following intakes were completed in the Critical Incident (CI) inspections:

- Intake: #00107443/CI#M576-000007-24 was related to an incident resulting in a significant change in condition for a resident.
- Intake: #00108012 /CI#M576-000010-24 was related to an allegation of abuse.
- Intake: #00111871/CI#M576-000014-24 was related to an allegation of abuse.
- Intake: #00111920/CI#M576-000015-24 was related to the management of an infectious disease outbreak.

The following intake was completed in this follow up inspection:

- Intake: #00109698 was related to a Follow up inspection regarding a compliance order issued under FLTCA, 2021 102 (2) (b).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2023-1584-0005 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Gabriella Kuilder (000726)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care-Consent

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to obtain consent for a medication order.

Rationale and Summary

On a specific day a physician ordered medications for a resident. A progress note written on a specific day by a registered nurse indicated the medication order was sent to the pharmacy and a message had been left for the resident's substitute decision maker (SDM).

Review of the Medication Administration Record (MAR) for the resident during a specific month indicated the new medication was initiated on a specific date.
A progress notes on a specific date by a staff member indicated the SDM would be away on vacation for a specific time period, and an alternative contact was provided.

During an interview, with the specific staff member they stated that consent was

required for medication orders and that consent had not been obtained by the registered nurse for the medication order from a specific date for the resident.

During an interview with the Director of Care (DOC) they stated that consent is required for all medication orders.

Failure to obtain consent for medication orders presents a potential risk to resident safety and well-being.

Sources- a resident's medical record, and interviews with multiple staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Rationale and Summary

A review of a Critical Incident System (CIS) report, indicated that an allegation of abuse towards a resident by a staff member occurred on a specific date and time, was not immediately reported to Ministry of Long-Term Care (MLTC).

During an interview with a specific personal support worker (PSW) they verified that on the specific date, and time they witnessed an alleged incident of abuse by another staff member towards the resident, and they did not immediately inform their supervisor of the alleged incident.

During an interview with the Director of Care (DOC), they verified the PSW did not immediately report the alleged abuse to their supervisor. The DOC indicated staff were expected to immediately report an allegation of abuse to their supervisors. DOC indicated the PSW informed them of the alleged incident of abuse at a later time on the specific day the alleged incident occurred.

A review of the home's Critical Incident Reporting Policy & Procedure indicated that a person who has reasonable grounds to suspect that 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 shall immediately report the suspicion and the information upon which it is based to the Director.

A review of the home's Abuse and Neglect of Residents Policy and Procedure, indicated that all employees were legally obligated to immediately report any incident or suspected incident of abuse or neglect of residents, and any employee who witnessed or suspects abuse or neglect of a resident by another must verbally report the incident immediately to a registered staff, a manager and/or the manager on call if outside of regular business hours.

Failure to immediately report witnessed or suspected abuse to the Director placed residents at future risk of of further abuse.

Sources: Critical Incident System (CIS) report; resident record's; Critical Incident

Reporting Policy & Procedure; Abuse and Neglect of Residents Policy and Procedure, and interviews with multiple staff.