

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 28, 2024
Original Report Issue Date: July 12, 2024
Inspection Number: 2024-1584-0002 (A1)
Inspection Type: Complaint Critical Incident
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

AMENDED INSPECTION SUMMARY

This report has been amended to:
remove a duplicate non-compliance (NC) #004 and amend with NC #003.

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This report has been amended to:
remove a duplicate non-compliance (NC) #004 and amend with NC #003.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 21, 24- 28, 2024 and July 2-5, 8, 9, 11, 2024

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00107260/CI: M576-000005-24 was related to improper/incompetent treatment of a resident.
- Intake: #00113890/CI: M576-000019-24 was related to a fall of resident.
- Intake: #00116296/CI: M576-000023-24 was related to alleged physical abuse of resident by a resident.

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- Intake: #00117231/CI: M576-000024-24 was related to a fall of resident.

The following complaint(s) were inspected:

- Intake: #00114768 was a complaint related to resident care.
- Intake: #00116182 was a complaint related to medication management.
- Intake: #00117009 was a complaint related to use of slings.
- Intake: #00118268 was a complaint related to alleged verbal abuse to resident by staff, temperature of food, and air temperature.
- Intake: #00118294 was a complaint related to resident behaviours.
- Intake: #00119171 was a complaint related to alleged abuse to resident by resident.

The following intakes were completed in this inspection:

- Intake: #00114946/CI: M576-000022-24 was related to a fall of resident.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a written plan of care for two residents, related to use of sling, sets out clear directions to staff and others who provide direct care to the resident.

Sources: observations of two residents; clinical record of two residents; the licensee's Minimal Lift Policy, 0401-03-09, issue date: July 2012, review date: November 2017; and interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

The licensee has failed to ensure that a resident was assisted by two staff, during all

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transfers, as set out in the plan of care.

Sources: resident health care records; and interview with staff.

(A1)

The following non-compliance(s) has been amended: NC #003

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 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.

1) The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents is complied with, related to an allegation of improper care by staff towards a resident.

Sources: Critical Incident System (CIS) report #-M576-000005-24, Abuse and Neglect of Residents Policy and Procedure, O202-02-05, revision date February 2024; and interviews with staff.

2) The licensee has failed to ensure an allegation of abuse that was reported to staff was immediately reported to the Director.

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Sources: Abuse and Neglect of Residents Policy and Procedure, 0202-02-05, revision date February 2024; and interviews with staff and a resident.

(A1)

The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (b)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and

The licensee has failed to ensure that the written procedures for initiating

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complaints to the licensee and for how the licensee deals with complaints, included information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry.

Sources: the licensee's complaint policy titled "Investigation: Resident/Family Feedback: Employee Complaints (Bill 168): AODA Complaints", Administration O202-04-11, issue date July 2010, revision date November 2022.

WRITTEN NOTIFICATION: Air temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature

s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure the home is maintained at a minimum temperature of 22 degrees Celsius.

Sources: St. Lawrence Lodge Air Temperature Daily Logs; and interviews with a resident and staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to

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nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was reassessed by a registered dietitian when they returned from the hospital.

Sources: resident health care records; and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviors

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Sources: resident health care records; and interview with staff.

WRITTEN NOTIFICATION: Dealing with complaints

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NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response made to a verbal complaint made to the licensee or a staff member concerning the care of a resident included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Sources: interview with staff.