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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2014	2014_285546_0016	O-001056-13 X O-001146-13	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

SUSAN WENDT (546)

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): April 22 and 23, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Worker (PSW) and the Business Office Manager.

During the course of the inspection, the inspector(s) reviewed resident health care records, including plans of care, medication and treatment records, PSW care flow sheets and the responsive behaviour program. The home's policy to promote zero tolerance of abuse was reviewed, in addition to printed admission package information given to residents and families, and to new staff hires.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 104. Reports re: Critical Incidents specifically s. 104 (1) 4. in that the home did not include the analysis and follow-up action.

A Mandatory Critical Incident report was received in October 2013 for a resident to resident abuse incident in the Home, which occurred in October 2013. The Ontario Provincial Police (OPP) was called. The Mental Health Crisis line was called. The Ministry was notified. The POAs were notified.

In April 2014, during an interview with the DOC, while reviewing a critical incident, the DOC concurred that the critical incident report did not include:
* the OPP follow-up - there was no date or time of visit, no report number, no outcome of their visit;
* the immediate action taken specifically for a resident
* the long term actions planned to correct and to prevent recurrence.

As of April 2014, there were no amendments to the Critical Incident report following the original submission to the Director. [s. 104. (1) 4.]

2. The licensee has failed to comply with O.Reg 79/10, s. 104. Reports re: Critical Incidents specifically s. 104 (1) 4. in that the home did not include the analysis and follow-up action.

A Mandatory Critical Incident report was received in November 2013 for an alleged staff to resident abuse incident in the Home. The Ontario Provincial Police (OPP) was called. The Ministry was notified. The POA was notified.

In April 2014, during an interview with the DOC, while reviewing a critical incident, the DOC concurred that the critical incident report did not include:
* the OPP follow-up - there was no date or time of visit, no report number, no outcome of their visit;
* the long term actions noted in the report were actually immediate actions - no long term actions were indicated;
* the outcome of investigation.

As of April 2014, there were no amendments to that Critical Incident report following the original submission to the Director. [s. 104. (1) 4.]

Issued on this 25th day of April, 2014

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

Susan Wendt