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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 7, 2016	2016_334565_0004	006604-16	Critical Incident System

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

Long-Term Care Home/Foyer de soins de longue durée

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

MATTHEW CHIU (565)

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): March 10, 14, 15, and 16, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, and Family Member.

The inspector conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from sexual abuse by anyone.

The applicable definition of sexual abuse in O. Reg. 79/10 of the Long-Term Care Homes Act is "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Record review of Critical Incident System (CIS) report and progress notes revealed on an identified date, PSW #100 and #102 observed resident #001 touching resident #002 on an identified part of the body. Resident #002 was wearing his/her clothes with a shawl. The PSWs separated the residents and removed resident #001 from the area. Resident #002 did not sustain any injury or demonstrate any distress after the incident.

Record review of residents #001 and #002's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments revealed they had the same identified Cognitive Performance Scale score. Interviews with staff members and a family member of resident #002 indicated resident #002 was unable to give consent.

Interviews with PSWs #100 and #102 indicated on the identified date, they observed resident #001 touching resident #002 on an identified part of the body. When PSW #100 spoke to resident #001 he/she removed his/her hand from resident #002. The staff members separated and monitored the residents.

Interviews with RPN #103 and the DOC confirmed the home failed to protect resident #002 from sexual abuse. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments.

Record review of resident #001's RAI-MDS assessments, progress notes, assessment records and plan of care revealed that resident #001 demonstrated responsive behaviours towards staff with difficulty in redirection. The resident was assessed by the Mobile Support Team (MST) of the North Simcoe Muskoka Behavioural Support System and a Psychiatrist in 2014 and early 2015. The MST had recommended behavioural interventions to manage the resident's behaviours and they were incorporated into the plan of care for the resident.

Further review of the resident's progress notes and assessment records indicated the resident continued to demonstrate the responsive behaviours after he/she was assessed by the MST and the Psychiatrist in early 2015. The responsive behaviours escalated in late 2015. There was no other assessment or reassessment conducted for the resident's behaviours.

Interviews with PSWs #100, #102, RN #101, RPN #103 and the DOC confirmed that the resident had ongoing responsive behaviours. The DOC further confirmed the behavioural interventions were ineffective to manage the resident's responsive behaviours and no assessment or reassessment was taken in response to the needs of the resident's behaviours. [s. 53. (4) (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 that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments and reassessments, to be implemented voluntarily.

Issued on this 8th day of April, 2016

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

Original report signed by the inspector.