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 prévue 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 soins de longue durée**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 4, 2019 | 2019_671684_0011 | 012844-18, 023732-18, 027174-18, 029852-18, 030117-18, 030420-18, 031730-18, 033248-18, 000542-19, 000729-19, 000847-19, 001026-19, 004737-19, 006252-19 | Critical Incident System |

### Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

### 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

SHELLEY MURPHY (684), COREY GREEN (722), RYAN GOODMURPHY (638), STEVEN NACCARATO (744)

### 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 18-22, 25-26, 2019.**

**The following intakes were inspected during this Critical Incident System Inspection:**

**Three logs related to missing controlled substances;**

**Five logs related to falls with injuries;**

**Four logs related to alleged abuse and neglect;**

**One log related to an unexpected death, and;**

**One log related to a missing resident.**

**The Inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant policies, procedures, programs and resident health care records.**

**A Follow Up inspection #2019_671684_0012, a Complaint inspection #2019_671684_0013, and Other inspection #2019_671684_0014, were conducted concurrently with this inspection.**

**Please note: A compliance order related to s. 6 (9)(1), was identified in this inspection has been issued in Follow Up inspection report # 2019_671684_0012, which was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Cares (Co-DOCs), Environmental Services Manager (ESM), Restorative Care Coordinator, Volunteer Coordinator, Culinary Manager, Life Enrichment Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, and residents.**

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

**Continence Care and Bowel Management**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 set out in the plan of care was provided to the resident as specified in the plan.

On a specified date in 2019, the licensee submitted a critical incident (CI) report related to an allegation of staff-to-resident neglect to the Director, involving PSW #136 and the care needs of resident #020.

Inspector #722 reviewed resident #020's care plan, which indicated a specific intervention that was to be implemented. This intervention was initiated three days prior to the day the CI was reported to the Director, and was discontinued one day after the day of the incident.

The point of care (POC) documentation was reviewed by Inspector #722, which indicated that direct care staff were required to make entries specific to the resident's care at hourly intervals. All hourly entries were made during this period by direct care staff, which included the assessment findings, staff initials, and time of assessment. Except for the hourly entries from 0700 to 1300 hours on two specified days in 2019, the entry fields were blank.

Inspector #722 reviewed the POC module online, which indicated that on the two specified dates as previously mentioned, the direct care staff were prompted each hour from 0700 to 1300 hours to complete the intervention documentation, and these prompts remained highlighted in red. During separate interviews with Inspector #722, PSW #111 and the Director of Care (DOC) indicated that these buttons appeared each hour, as a prompt to the PSW to complete the assessment, and confirmed that the buttons were highlighted in red, which indicated that the assessments had not been documented.

Inspector #722 reviewed a specific licensee policy, which indicated that the PSW will:
- "Be accurate and timely documentation [sic] were completed in POC ; and
- Ensure they participate in any additional resident assessments".

During an interview with Inspector #722, PSW #136 confirmed that they were working on the two specified days in 2019. PSW #136 also confirmed that resident #020 was in their primary care assignment, which meant that they were responsible for the resident's care and documentation during the shift. PSW #136 indicated that they were not aware that they were required to complete the hourly intervention documentation, and confirmed that they had not completed the hourly assessments for resident #020 on the two specified dates in 2019, during their shift.

During an interview with Inspector #722, PSW #138 indicated that they were aware of the

hourly documentation for residents. The PSW indicated that they understood that this assessment information was used to develop the resident's care plan.

Inspector #722 interviewed the DOC, who indicated that the specified assessment was to be completed for every resident admitted to the home. The DOC explained that the expectation was that direct care staff completed these assessments every hour for a specific period of time. The DOC indicated that the assessment was automatically added to the resident's care plan, and that the prompts were generated each hour in POC, so that the PSWs were aware that the assessments needed to be completed. The DOC also confirmed that PSWs were assigned to provide care to a specific group of residents, and that the PSW was responsible for completing documentation for residents in their assignment, including the hourly assessments. The DOC confirmed that PSW #136 should have completed the hourly assessments for resident #020 during their shifts, on the two specified days in 2019, and confirmed that these were not completed. [s. 6. (7)]

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that it was complied with.

In accordance with Ontario Regulation 79/10, r. 114 (2) the licensee was required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Inspector #744 reviewed the Resident Care Manual- Medication Management System, titled, "Resident Rights, Care and Services-Medication Management- Narcotics and Controlled Substances", last revised October 07, 2013, which indicated that registered staff must "Immediately notify the Director of Care in the event of missing and or misappropriated narcotics or controlled substances, inaccurate narcotic counts."

Inspector #744 reviewed a CI report submitted to the Director on a specified date in 2019, which outlined a missing controlled substance for resident #015.

Inspector #744 interviewed RPN #127 who indicated that if controlled substances were unaccounted for, they called a supervisor immediately and awaited for further instructions on how to proceed.

RPN #132 was interviewed by Inspector #744, who confirmed that medication was noticed to be missing at a specified time but was not immediately reported because they had been called away for other duties. RPN #132 reported the missing medication to RPN #128 at shift change medication count, at which time RPN #128 reported the missing medication immediately to the manager on call.

During an interview with the DOC, Inspector #744 confirmed that RPN #132 had not followed the policy to notify the DOC of the missing controlled substances immediately. [s. 8. (1) (b)]

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

On a specified date in 2019, the licensee submitted a CI report related to an allegation of staff-to-resident neglect to the Director, involving PSW #136 and the care needs of resident #020. Please refer to WN #1.

Inspector #722 reviewed the CI report and licensee's investigation file related to this allegation of staff-to-resident neglect, and there was no indication in the CI report that the resident had been notified of the results of the investigation. The investigation file included an Administration Check-List, which indicated that the investigation into this incident was completed on a specified date in 2019.

During an interview with resident #020, the resident indicated that they recalled reporting the incident of alleged neglect on a specified date in 2019, but were unable to remember specific details. Resident #020 indicated that they recalled telling PSW #138 about their concerns, and they also spoke to RPN #120 about the incident. The resident indicated that the staff had not spoken to them about their concern since the original complaint, and that they were not aware of any actions taken by the home.

During an interview with Inspector #722, RPN #120 indicated that they had interviewed resident #020 about this incident, and participated in the investigation. RPN #120 confirmed that they had never spoken further with resident #020 about the incident, including the outcome of the investigation.

The licensee's policy, "Abuse - Zero-Tolerance Policy for Resident Abuse and Neglect", last revised June 2, 2017, was reviewed by Inspector #722, and indicated the following: "Upon being notified of abuse or neglect of a resident, the Administrator or Director of Care will: Report the results of the investigation to the resident or the resident's substitute decision-maker upon completion of the investigation".

The DOC indicated in an interview with Inspector #722, that the investigation was completed on a specified date in 2019, and that they had not spoken further with resident #020 after the investigation was completed. The DOC indicated that if neither they nor RPN #120 had notified the resident of the outcome of the investigation, than likely the resident had not been notified of the outcome. [s. 97. (2)]

---

**Issued on this 1st day of May, 2019**

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

**Original report signed by the inspector.**