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

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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_0013	033474-18, 000679-19, 001090-19	Complaint

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), RYAN GOODMURPHY (638), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 18-22, 25-26, 2019.

The following intakes were inspected during this Complaint inspection:

-One log related to alleged neglect, care and maintenance concerns;

-One log related to Residents' bill of rights/Privacy, and;

-One log related to wound care.

A Follow Up inspection #2019_671684_0012, Critical Incident (CI) inspection # 2019_671684_0011, and Other inspection #2019_671684_0014, were conducted concurrently with this inspection.

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.

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), and Housekeeper, residents and families.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Neglect is defined in the Ontario Regulation (O. Reg) 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview with resident #010, they requested that Inspector #638 speak with resident #027 as they had something they wished to discuss with an Inspector. Inspector #638 interviewed resident #027 who stated that on a specified date and shift in 2019, a PSW came in to provide care to them as they required assistance. The resident alleged that the PSW only partially completed the care and subsequently left the resident uncared for. After a short period of time, the resident indicated that they rang their call bell for assistance. The resident indicated that the PSW never finished assisting them with their care. Another, PSW #110 completed the remainder of the resident's care. The resident indicated that they wrote a letter regarding the incident and provided it to staff on a specified day in 2019.

Inspector #638 reviewed the letter written by resident #027, which alleged that PSW #142 had not completed the care needs of resident #027, on a specified day in 2019. The letter alleged that PSW #142 never returned to complete care nor had they responded to resident #027's call bell. The letter stated that PSW #110 had responded to

their needs.

During an interview with Inspector #638, PSW #110 indicated that they came in for their shift on a specified day in 2019. The PSW stated that when they arrived to the unit, there were multiple resident call bells ringing and PSW #142 was at the nursing desk. PSW #110 indicated that they responded to resident #027's call bell and found the resident's care needs were not met. The PSW also indicated that PSW #142 had not completed their required Point of Care (POC) task documentation.

Inspector #638 reviewed the "Point of Care Audit Report" on the Home Area for the shift PSW #142 worked which was on a specified day in 2019. The Inspector identified in the report that each of the residents on that unit were missing documentation related to their scheduled care during the identified shift.

During an interview with Inspector #638, Staff Educator #120 indicated that they were made aware of the incident and they had initiated an investigation into the incident. The Staff Educator indicated that PSW #110 reported at the beginning of their shift that multiple call bells were ringing, while PSW #142 was at the desk. The Inspector reviewed the incident with the Staff Educator who indicated that resident #027's care needs were not met during this incident.

Inspector #638 conducted an interview with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC) #123 and Staff Educator #120. During the interview they indicated that PSW #142 was working a specified shift on the unit where the reported incident occurred. The Administrator indicated that the PSW's priority should have been responding to resident care needs.

2. In an interview with Inspector #638, resident #027 stated that a PSW came in to provide care and then left them without fully completing the care. Please refer to WN #1, finding #1 for details.

During an interview with Inspector #638, PSW #110 indicated that they came in for their shift on a specified day in 2019. The PSW stated that when they arrived to the unit there were multiple resident call bells ringing and PSW #142 was at the nursing desk. PSW #110 stated they immediately reported their concerns related to PSW #142's care to RN #121.

In an interview with Inspector #638, RN #121 indicated that they recalled a PSW had

complained to them regarding another PSW but could not recall the staff or what they stated. The RN indicated they had to remind the PSW to complete certain tasks and that the PSW was ignoring certain direction provided by the RN. The RN indicated that they had not reported these concerns and would have taken the staff member aside to discuss their actions if they worked together again.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, indicated that the most senior administrative personnel or charge nurse would promptly notify the Administrator or DOC of the alleged, suspected or witnessed incident of abuse or neglect.

Inspector #638 conducted an interview with the Administrator, DOC, Co-DOC #123 and Staff Educator #120. They indicated that whenever staff became aware of an incident of improper care or neglect, they immediately reported to a registered staff member or if they were the registered staff member and it was after hours, they immediately reported to the manager on call, and the manager on call reports to the Director. Upon reviewing the RN's account of the shift, the Administrator indicated RN #121 should have reported to the manager on call because the PSW not following direction could have been considered insubordination and could have caused unsafe working conditions. [s. 20. (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 that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. 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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the suspicion of 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 was immediately reported to the Director.

In an interview with Inspector #638, resident #027 stated that a PSW came in to provide care and then left them without fully completing the care. Please refer to WN #1, finding #1 for details.

Inspector #638 reviewed the CIS report, which was related to the aforementioned incident. The CIS report indicated that the incident had occurred on a specified date in 2019 and was reported to the Director three days later.

In an interview with Inspector #638, Co-DOC #123 indicated that they became aware of the incident on a specified day in 2019, when RN #118 reported that resident #027 had given them a letter which alleged improper care from PSW #142. The Co-DOC indicated they directed the staff responding to the incident to write their account and drop off the information under Staff Educator #120's door because they would complete the investigation into the incident.

During an interview with Inspector #638, Staff Educator #120 indicated that they were in charge of the investigation, but only became aware of the incident two days after the

incident, because they were off the previous day. The Staff Educator indicated that they were not aware that the incident had been reported to the Director because they were off when management became aware.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, indicated that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident or 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 has occurred, shall immediately report the suspicion and the information upon which it is based to the Ministry of Health and Long Term Care.

Inspector #638 conducted an interview with the Administrator, DOC, Co-DOC #123 and Staff Educator #120. The Administrator indicated that the process for reporting improper care was to immediately report the incident to a manager. The Administrator indicated that they found out about the incident on a specified day in 2019, (one day after the incident) and believed it had just been a complaint issue due to when they found out and that there was some confusion as to if this incident was suspected to be improper care/neglect. The Administrator indicated that they missed the immediate reporting process due to the confusion surrounding the incident. [s. 24. (1)]

Issued on this 30th day of April, 2019

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

Original report signed by the inspector.