Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Feb 5, 2020	2020_768693_0003	020774-19	Complaint

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

MELISSA HAMILTON (693), 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): January, 20 to 24, and 27 to 30, 2020.

The following intake was inspected upon during this Complaint inspection:
-one intake, regarding notification of medication changes, a resident fall, and a resident to resident altercation.

JENNIFER LAURICELLA (#542), and LISA MOORE (#613), attended this inspection.

Critical Incident System (CIS) inspection #2020_768693_0004 and Follow Up inspection #2020_768693_0005 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (CDOCs), Acting Staff Education Coordinator, Resident and Family Service Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A complaint was submitted to the Director, which indicated that a family member of resident #004, was not immediately notified of a resident to resident altercation involving resident #004 on an identified date.

Inspector #744 reviewed resident #004's electronic progress notes from an identified date, which indicated that RPN #103 had witnessed resident #004 in resident #007's bedroom. The progress note further indicated that RPN #103 overheard resident #004 speaking a specific phrase, and resident #007 responding. In addition the progress note identified that RPN #103 had witnessed resident #004 exhibiting a specified behaviour towards resident #007 and resident #004 was immediately redirected.

Inspector #744 reviewed the home’s policy, titled, “Resident Rights, Care and Services- Plan of Care- Plan of Care (Care Planning)”, last revised September 24, 2019. The policy identified that the purpose of the care plan was to provide clear direction to staff and others who provided care.

During an interview, RPN #103 indicated that a specified intervention was provided to resident #004 when able, prior to the incident on an identified date. RPN #104 further indicated that after the incident, management made the specified intervention for resident #004 mandatory, during specific shifts.

Inspector #744 reviewed resident #004’s current electronic care plan which indicated, that the specified intervention was to be provided to resident #004, under an identified condition.

In a subsequent interview, RPN #103 indicated that the plan of care was unclear and the direction from management did not match the direction indicated in the care plan.

Inspector #744 interviewed the DOC, who indicated that resident #004 currently required the specified intervention, during specific shifts. The DOC further indicated that the specific words on the care plan, that described an identified condition, related to the specified intervention, as identified in the care plan, were unclear for staff. The DOC also indicated that the care plan would need to be revised to be more clear. [s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident abuse of a resident by anyone that the licensee knows of is immediately investigated.

See WN #1, finding #1, for further details.

Inspector #744 reviewed the homes policy titled, “Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect”, last revised April 25, 2019. The policy identified that upon being notified of abuse or neglect of a resident, the Administrator or Director of Care will follow the investigation procedures using the Resident Rights, Care and Services- administration Investigation Checklist.

During an interview, the Administrator indicated that they were first made aware of the progress note outlining the incident from an identified date, during a morning manager's meeting an identified number of days after the incident. The Administrator further indicated that they should have investigated the incident immediately because of their initial suspicion of abuse; however, an immediate investigation was not conducted. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident abuse of a resident by anyone that the licensee knows of is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director, which indicated that a family member of resident #004 was not notified on the date that a medication was ordered for this resident.

Inspector #744 reviewed the “LTC Prescriber’s Order Form”, for resident #004, which indicated a change in the dosage of identified medications, which had been ordered from the prescriber on an identified date.

Inspector #744 reviewed resident #004’s health care records and identified in the Electronic Medication Administration Record (eMAR) that an ordered medication was not administered until a specific number of days after being ordered.

During an interview, RPN #113 indicated that the drug order should have been processed and the SDM called for consent on the same day the order was received. RPN #113 further indicated that they may not have had enough time to process the medication order or to call the SDM.

Inspector #744 interviewed RPN #112 who stated that on an identified date, they completed processing the medication order from an earlier identified date, and a call to the SDM was made. They further indicated that the order should not have sat for a while and should have been processed right away.

During an interview, the DOC indicated that the order should have been processed within 24 hours, to follow the physician’s request to ensure the resident had the medication on the date prescribed. The DOC further stated that the SDM should have been called right away. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.

See WN #1, finding #1, for further details.

Inspector #744 reviewed the homes policy, titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified that the most senior administrative personnel must notify the SDM within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect.

During an interview, RPN #103 indicated they routinely notify SDMs regarding resident concerns. RPN #103 further stated that they were the witness of the incident on an identified date, and should have notified the SDM immediately.

During an interview, the DOC indicated that the SDM must be notified after there is an incident of concern between residents. The DOC further indicated that RPN #103 was disciplined for not notifying the SDM immediately after the incident. [s. 97. (1) (b)]

Issued on this 6th day of February, 2020

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

Original report signed by the inspector.