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
Jun 5, 2020	2020_822613_0010	001967-20, 002189-20, 003236-20, 005280-20, 005479-20, 006621-20, 008965-20	Critical Incident System

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

LISA MOORE (613), JENNIFER NICHOLLS (691)

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): May 20 - 22 and 25 - 29, 2020.

The following intakes were inspected during the inspection:

Four Critical Incident (CI) reports that were submitted to the Director regarding allegations of resident to resident physical altercations;

Two CI reports that were submitted to the Director regarding allegations of resident to resident abuse;

One CI report that was submitted to the Director regarding allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Care Service Coordinator from Jarlette Health Services, (CSC), Director of Care (DOC), Co-Director of Care (CO-DOC), Staff Education Coordinator (SEC), Registered Nurses (RNs), Behavioural Supports Ontario staff (BSO), and Personal Support Workers (PSWs).

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation files and policies, procedures and programs.

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.

- **1 WN(s)**
- **0 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of abuse involving resident #001.

Inspector #691 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of staff to resident abuse involving resident #001. The CI report indicated that resident #001 was alleged to have been abused by PSW #107 during a shift on a specific date. The CI report further indicated that resident #001 reported to RPN #100 on a specific shift on the following date, that PSW #107 had been rough with them on a specific date, resulting with a visible injury.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the use of physical force by anyone other than a resident that causes physical injury or pain."

A review of the licensee's policy titled "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last updated on January 13, 2020, indicated that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred would immediately report the suspicion and the information upon which it is based to the Ministry of Health and Long-Term Care: • Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident. Also, staff members, volunteers, substitute decision-makers, family members or any other person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager was on site at the Home.

A review of the resident's progress notes, dated on a specific date, indicated that RPN #100 had identified that resident #001 had a visible injury, after receiving report from resident #001 regarding the alleged abuse by PSW #107.

A review of the home's internal investigation notes identified that on a specific date, the on call Nurse Manager (NM) received a voice mail from RPN #100 describing the alleged abuse to resident #001 by PSW #107. A further review of the home's internal investigation notes included interviews that the home's management had conducted with the staff members involved with the incident. The investigation notes identified that on a specific date, RPN #100 reported to Registered Nurse (RN) #101 an allegation of abuse with resident #001 that occurred on a previous specified shift. The investigation notes further indicated that RN #101 directed RPN #100 to call the home's on call manager to report the allegation of abuse of resident #001. RPN #100 indicated that they left a voice mail for the on-call manager on their office extension; therefore, not following the licensee 's policy to call their on-call telephone number. The Inspector conducted a further review of RN #101's interview notes which indicated they did not follow the policy appropriately and they did not ensure that RPN #100 spoke to the on-call manager to report allegation of abuse towards resident #001.

During separate interviews with PSW #104, PSW #105, RN #102, and RN #103, they all indicated that all staff were to report any incidents of suspected or confirmed abuse of a resident immediately.

During an interview with RPN #100, they identified to the Inspector, that staff were to report any incidents of suspected or confirmed abuse of a resident to the RN, who in turn would report it to the on-call manager. RPN #100 indicated they had not followed the licensee's policy and did not immediately speak to a manager to report the alleged abuse, rather they had left a message for the on call manager; therefore, they did not report the allegation of abuse immediately.

During an interview with the Director of Care (DOC), they identified that staff were to report all witnessed, suspected or confirmed incidents of resident abuse to management immediately at the time they become aware.

The licensee has failed to ensure that the homes written policy to promote zero tolerance of abuse was complied with. [s. 20. (1)]

Issued on this 18th day of June, 2020

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

Original report signed by the inspector.