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
Apr 5, 2022	2022_907692_0009	017542-21, 019109-21, 019989-21, 020190-21, 021061-21, 001255-22, 002482-22, 003210-22, 003601-22	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

SHANNON RUSSELL (692), 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 7-11, and 14-18, 2022.

The following intakes were inspected upon during this Critical Incident System inspection:

-One intake, related to an unexpected death of a resident;

-Two intakes, related to injuries that resulted in residents being transferred to the hospital;

-Two intakes, related to incidents of resident-to-resident sexual abuse; and,

-Four intakes, related to allegations of staff to resident abuse.

Complaint inspection #2022_907692_0007 and Follow Up inspection #2022_907692_0008 inspections were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Medical Director, Physician Assistant (PA), Infection Prevention and Control (IPAC) Lead, Staff Educator, Housekeeper, Behavioural Support Ontario (BSO) staff, Restorative Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had their rights respected, related to being treated with dignity and respect.

There had been an allegation of abuse from a Personal Support Worker (PSW) towards a resident. As well, two PSWs had transferred the resident from one location to another location in a manner that caused the resident to identify they felt "disgusted and embarrassed" by the PSWs actions.

Care was not provided to the resident in a way that respected the resident's dignity.

Sources: Critical Incident System (CIS) report; a resident's health care records; internal investigation notes; licensee policy titled "Resident Rights, Care and Services-Nursing and Personal Services-Personal Care", created September 16, 2013; interviews with a resident, DOC, the Interim Administrator, and other staff. [s. 3. (1) 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 ensuring every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality, and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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 regarding incontinence checks was provided to eight residents, as specified in the plan.

On a specific shift, it had been reported to a Registered Nurse (RN) that 14 residents were found to be wet from incontinence during the second care rounds, as they had not been checked during first care rounds, resulting in five residents sustaining skin integrity concerns.

A review of the 14 residents' plan of care identified that eight of those residents had a focus regarding urinary incontinence, which indicated that staff were to check for incontinence during care rounds. As well, two resident's plan of care indicated they were to be checked at specific times.

Direct care staff identified that if the resident's plan of care indicated they were to be checked during care rounds, staff were to check and provide care as required. The DOC and Interim Administrator indicated that a PSW had not provided care to the eight residents as identified in their plan of care, and they should have.

Consequently, there was minimal risk to the eight residents by not checking them for incontinence during care rounds, which could have increased the risk of developing skin integrity concerns.

Sources: CIS report; health care records for 14 residents; the home's policy titled, "Resident Rights, Care and Services-Nursing and Personal Services-Personal Care", created September 16, 2013; interviews with residents, DOC, the Interim Administrator, and other staff. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 the home's policy for prevention and management of falls was complied with when a resident experienced a fall.

Ontario Regulation (O. Reg.) 79/10, section 48 (1) 1. required the home to have written policies and procedures for the falls prevention and management program. Specifically, registered staff did not comply with home's policy titled, "LTC Falls Prevention and Management – Program", which directed registered staff to initiate a Head Injury Routine (HIR), if head injury was evident.

A resident experienced an unwitnessed fall, sustaining a specific injury. Although a specified assessment was initiated, the assessments were not completed in their entirety.

The DOC indicated that the assessments should have been fully completed by registered staff.

There was minimal risk to the resident as they were not fully assessed as per the home's policy after sustaining an injury.

Sources: the home's policy titled "LTC Falls Prevention and Management – Program" revised date of March 04, 2022; CIS report; a resident's health records; the home's internal investigation notes; interviews with the DOC, and other staff. [s. 8. (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 ensuring where the Act or 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, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #4: 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 abuse policy was complied with.

A resident reported to a RN that a PSW had spoken to them inappropriately while providing the resident care. The RN documented a progress note, which indicated when the resident made the allegation; the PSW was transferred to another floor.

The licensee policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", indicated to immediately remove the accused abuser from the resident, and send the accused staff member home with pay pending the completion of the investigation.

The Interim Administrator indicated that the PSW had not been sent home pending the investigation, and they should have been.

There was minimal risk of harm to the resident by the home not complying with the zero tolerance of abuse policy.

Sources: CIS report; a resident's health care records; internal investigation notes; licensee policy titled "Resident Rights, Care and Services-Abuse- Zero-Tolerance Policy for Resident Abuse and Neglect", last revised February 25, 2022; interviews with a resident, DOC, the Interim Administrator, and other staff. [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 ensuring that the home complies with the zero tolerance of abuse policy, to be implemented voluntarily.

WN #5: 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 ensure that a resident was protected from abuse by a PSW.

Section 2 (1) of O. Reg. 79/10 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident”.

A resident reported to a RN that a PSW had treated them badly when being assisted with care. The PSWs actions had made the resident feel that it had been their fault that they required care, when they had received care a short time prior.

In an interview with the resident, they indicated that they recalled the incident and it made them feel belittled, like they had done something wrong; the resident was crying during the interview. The Interim Administrator identified that the PSW’s actions were inappropriate, as they had caused the resident to feel increased emotional distress.

The above finding is further evidence to support the order issued on December 10, 2021, during a complaint Inspection 2021_824736_0022, to be complied February 14, 2022.

Sources: CIS report; a resident’s progress notes and assessments; internal investigation notes; licensee policy titled "Resident Rights, Care and Services- Abuse- Zero-Tolerance Policy for Resident Abuse and Neglect", last revised February 25, 2022; interview with the resident, DOC the Interim Administrator, and other staff. [s. 19. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that screening measures were conducted in accordance with the regulations before hiring a PSW; specifically, related to police record checks.

O.Reg. 79/10, s. 215 indicated that where a police record check was required before a licensee hired a staff member as set out in subsection 75(2) of the Act, the police record check was to be conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and, conducted within six months before the staff member was hired. The police record check was to be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

There was an allegation of verbal abuse from a PSW towards a resident. Inspector #692 reviewed the personnel file of the PSW and was unable to locate a completed vulnerable police record check on file for the staff member. The Interim Administrator provided a copy of a receipt for a vulnerable police check that had been initiated by the PSW as week prior.

The PSW identified to the Inspector that they had been working in the home for approximately three months and had just commenced the process of obtaining a police check. In an interview with the DOC, they indicated that all staff were to have a current completed vulnerable police record check on file prior to starting employment with the home. The DOC identified that the PSW did not have a vulnerable police record check on file.

Sources: CIS report; a resident’s health care records; internal investigation notes; a PSW personnel file; interviews with the PSW, DOC, the Interim Administrator, and other staff. [s. 75. (2)]

Issued on this 12th day of April, 2022

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

Original report signed by the inspector.