Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Original Public Report

Report Issue Date: March 31, 2023	
Inspection Number: 2023-1320-0004	
Inspection Type: Critical Incident System	
Licensee: Orillia Long Term Care Centre Inc.	
Long Term Care Home and City: Leacock Care Centre, Orillia	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20-24, 2023

The following intake(s) were inspected:

- One intake, which was related to an allegation of neglect of a resident; and
- Three intakes, which were related to allegations of staff to resident physical abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care provided clear direction to staff and others who provided direct care to the resident.

Rationale and Summary:

An allegation of neglect was reported related to a resident not receiving care during a specified time of day, resulting in a negative impact on the resident. The resident's care plan, that was in place at the time of the allegation, provided direction for staff to assist the resident with specified activities of daily living (ADL)s at a specified time of day; however, a separate section of the care plan indicated that staff were not to provide assistance at the specified time.

According to investigation notes, a Personal Support Worker (PSW), was following the direction on the care plan to not provide assistance to the resident at the specified time. Registered staff and the Director of Care (DOC) both agreed the care plan did not provide clear direction to staff.

Not having clear direction on the care plan related to the ADLs resulted in a moderate impact to the resident, as it caused a negative impact on a resident's health condition.

Sources: The home's investigation notes; a resident's care plan and POC documentation; Interview with a PSW, Registered staff, and the DOC.
[690]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by a PSW.

Section 2 (1) of the Ontario Regulations (O. Reg.) 242/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary

A PSW reported to a Registered Practical Nurse (RPN) that they had witnessed an incident in which another PSW responded inappropriately to a residents' responsive behaviours. The RPN failed to take

any action, and there was a second incident that occurred approximately two hours later involving the same PSW and a different resident. The PSW was observed to be attempting to assist a resident with a specified ADL, and when the resident displayed responsive behaviours, the PSW was observed to physically abuse the resident. The same RPN told the PSW to leave the resident alone but took no further action. The incident was not reported to the Charge Nurse (CN) until approximately five hours later, when the PSW had already left the home at the end of their shift.

A Registered Nurse (RN) and the DOC both stated that the resident was not protected from abuse by the PSW. They stated that the second incident could have been prevented if the PSW had been sent home after the first incident, as they should have been.

Failing to protect the resident from abuse by the PSW, resulted in a moderate risk to the resident.

Sources: The home's investigation notes; the home's Policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect", last revised July 5, 2022; Interviews with PSW staff, a RN, and the DOC. [690]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Rationale and Summary

The home's Zero Tolerance for Resident Abuse policy stated that any person who had reasonable grounds to suspect that abuse of a resident had occurred must immediately report their suspicion to the most Senior Administrative Personnel or CN, if no manager was on site. The policy further stated that the Senior Administrative Personnel or CN would immediately assess the resident, interview the accused staff member, and send the staff member home, pending completion of the investigation.

A PSW reported to a RPN that they were uncomfortable with how another PSW had responded to a resident's responsive behaviours. Investigation notes indicated that the RPN was told by the PSW that

the resident was resistive during care, and that the PSW was trying to calm the resident and had performed a physically abusive action towards the resident. No action was taken by the RPN, and the CN was not notified until approximately five hours later at the end of the shift.

Registered staff, the DOC and the Administrator all confirmed that the home's Zero Tolerance for Abuse Policy had not been complied with when the RPN failed to report the incident to the CN, and follow the steps in the policy.

Failure to comply with the home's Zero Tolerance for Resident Abuse policy resulted in a moderate risk to the residents, as the PSW continued to provide care to other residents, and resulted in a second incident occurring.

Sources: The home's investigation notes; the home's Policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect", last revised July 5, 2022; interviews with a PSW, RN, the DOC and the Administrator.
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