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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Modified Public Report Cover Sheet (M1)

Original Report Issue Date: July 14, 2023
Inspection Number: 2023-1320-0005 (M1)
Inspection Type: Complaint Critical Incident System
Licensee: Orillia Long Term Care Centre Inc.
Long Term Care Home and City: Leacock Care Centre, Orillia

Modified By	**Inspector who Modified Digital Signature**
Tracy Muchmaker (690)	Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.08.16 13:33:01 -04'00'

MODIFIED INSPECTION SUMMARY

This report has been modified to: This public inspection report has been modified to correct an error.

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Modified Public Report (M1)

Report Issue Date: July 14, 2023

Inspection Number: 2023-1320-0005 (M1)

Inspection Type:
Complaint
Critical Incident System

Licensee: Orillia Long Term Care Centre Inc.

Long Term Care Home and City: Leacock Care Centre, Orillia

Lead Inspector
Shannon Russell (692)

Modified By	**Inspector who Modified Digital Signature**
Tracy Muchmaker (690)	Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.08.16 13:33:24 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 7, 8, 9, 15, 16, 19, 2023 and offsite on June 14, 2023.

The following intake(s) were inspected:

- Three intakes, which were related to allegations of resident neglect; and,
- Three intakes, which were related to concerns submitted to the Director regarding resident neglect.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

MODIFIED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to

the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 29 (3) 7.

The licensee has failed to ensure that resident #003's physical functioning, and the type and level of assistance that was required relating to their activities of daily living was identified in the plan of care.

Rationale and Summary
While resident #003's plan of care included direction to staff related to the resident's continence care needs, it was identified that it did not provide specificity related to the type and level of assistance that was required by staff, relating to the resident's continence care needs.

The Director of Care (DOC) stated that the information should be included in resident #003's plan of care for staff to know what assistance level they were to provide.

Before the conclusion of the inspection, the Inspector observed that the resident's plan of care had been updated to reflect the current type and level of assistance required.

Sources: Critical Incident System (CIS) report; a resident's plan of care; review of the home's policy titled, "LTC Continence Care and Bowel Management-Program", last revised 17/05/2022; and interviews with direct care staff, registered staff and the DOC. (692).

Date Remedy Implemented: June 13, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 29 (3) 8.

The licensee has failed to ensure that resident #001's continence, including bladder and bowel elimination, was identified in the plan of care.

Rationale and Summary
While the resident's plan of care contained a section specific to toileting, it did not include information specific to the resident's bladder and bowel care needs.

The DOC stated that the information should be included in the resident's plan of care for staff to know what care needs the resident required.

Before the conclusion of the inspection, the Inspector observed the resident's plan of care had been updated to reflect their current continence needs.

Sources: CIS report; a resident's plan of care; review of the home's policy titled, "LTC Continence Care and Bowel Management-Program", last revised 17/05/2022; and interviews with direct care staff, registered staff and the DOC. (692).

Date Remedy Implemented: June 19, 2023

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that resident #001, and #002, who required continence care products, were provided with sufficient changes to remain clean, dry and comfortable.

Rationale and Summary
Direct care and registered staff identified that two residents required specific assistance and specified products for continence care, that was not provided to them.

The DOC indicated that the PSW had not provided both residents the assistance they required for continence care. There was a moderate impact and risk to the residents for not receiving the continence care that they should have.

Sources: CIS report; two resident's plan of care; the home's internal investigation notes; staff personnel file; review of the home's policy titled, "LTC Continence Care and Bowel Management-Program", last revised 17/05/2022; and interviews with direct care staff, registered staff, and the DOC. (692).

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for resident #003 was provided as specified in the plan.

Rationale and Summary
Resident #003's plan of care indicated that a specified intervention was to be in place at all times, which had been implemented previously. The Inspector observed on three occasions

staff not implementing the specified intervention. The resident identified to the Inspector that staff had previously implemented the specified intervention; however, they had not been implementing the specified intervention on a consistent basis.

Direct care staff, the DOC and Administrator identified that the resident's plan of care had indicated a specified intervention that was to be implemented at all times. They all acknowledged that they had not been consistent with the specified intervention, which would indicate the staff were not providing the resident with the care as set out in the plan of care.

There was a low impact and a low risk towards the resident for staff not following the plan of care regarding a specified intervention.

Sources: CIS report; complaints submitted to the Action Line; Inspector #692's observations; a resident's health care records; and interviews with a resident, direct care staff, the DOC, and the Administrator.

WRITTEN NOTIFICATION: Duty to Protect

NC #005 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 resident #003 was protected from neglect by staff.

The Ontario Regulations (O. Reg.) 242/22, s. 7., defines neglect 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".

Rationale and Summary
Resident #003 had requested the assistance of staff for care. A staff member responded to the request; however, the care was not provided to the resident for an extended period of time.

The resident had identified to the Inspector that they had notified the staff that they required care and that they had not received the care for an extended period of time.

The Administrator, DOC and the Regional Manager Operations, indicated that the resident had been neglected, as they had not been provided with the care that they had required for an extended period of time.

There was a moderate impact and risk to the resident for the inaction of staff resulting in a delay in them receiving the care that they required.

Sources: CIS report; complaints submitted to the MLTC Action Line; a resident's health care records; the homes internal investigation notes; staff personnel files; the home's policy titled, "LTC Abuse-Zero-Tolerance policy for resident abuse and neglect", last revised May 7, 2022; and interviews with the resident, direct care staff, the DOC, the Administrator, and the Regional Manager Operations.