Ontario

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

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

North District
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Original Public Report

Report Issue Date: April 18, 2024.
Inspection Number: 2024-1320-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Orillia Long Term Care Centre Inc.
Long Term Care Home and City: Leacock Care Centre, Orillia

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2024.05.09 11:52:54 -04'00'

Additional Inspector(s) Kehinde Sangill (741670)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-7, 2024.
The inspection occurred offsite on the following date(s): March 8, 2024.

The following intake(s) were inspected:

- one intake related to allegations of neglect and improper care of residents by staff;
- one intake related to a complaint submitted to the Director related to communication and medication management within the home;
- one intake related to an order issued to the home on January 18, 2024, related to O. Reg. 246/22 s. 55 (2) (b) (ii), for skin and wound, with a compliance due date of February 29, 2024; and,
- two intakes related to allegations of resident to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1320-0007 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by Amanda Belanger (736)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect residents from abuse, and neglect by a Personal

Support Worker (PSW).

Summary and Rationale
A PSW alleged to have witnessed another PSW not provide care to three residents in an appropriate manner, and the PSW did not report their observations until days later.

A review of the schedule indicated that the involved PSW worked additional shifts, prior to the home removing the staff member pending investigation.

The Director of Care (DOC) confirmed that the residents were not protected from abuse and neglect by the PSW.

Sources: Progress notes for three residents; internal investigation package; internal communications; staff schedule; and, interview with the DOC.

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WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Ministry of Long Term care (MLTC) received a CIS report related to resident-to-resident abuse that occurred on the day prior.

The Regional Clinical Manager/Interim Administrator confirmed that the incident was reported late to the director.

Failure to immediately report alleged resident-to-resident abuse to the Director had low impact on the residents.

Sources: CIS report; interview with Regional Clinical Manager/Interim Administrator.

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2) The licensee has failed to ensure that the allegation of improper care, and abuse of residents by a PSW, was immediately reported to the Director.

Summary and Rationale
A PSW alleged to have witnessed another PSW not provide care to residents in a timely and appropriate manner.

The PSW brought forward the allegations days later, however, the Director was not notified until the day after the allegations were brought forward.

The DOC indicated that the allegations should have been immediately brought forward and reported to the Director.

There was low impact to the residents, as a result of the allegations not immediately being reported to the Director.

Sources: CI report; internal investigation package; licensee policy titled "LTC Mandatory Reporting to MOLTC of Critical Incidents", last revised October 2022; and, interview with the DOC.

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3) The licensee has failed to ensure that the allegation of staff to resident abuse, involving a resident was immediately reported to the Director.

Summary and Rationale
A concern related to a resident was brought forward regarding an injury of unknown cause. The resident expressed that they were not sure where the injury had come from and were not sure if a staff member had caused the injury..

The Interim Administrator indicated that they were aware of the injury of unknown cause, however, did not report the allegation of abuse to the Director, and should have.

There was low impact to the resident by the home not reporting the allegation of staff abuse to the Director.

Sources: Resident progress notes; internal complaints log; licensee policy; interview with the Regional Clinical Manager/Interim Administrator.

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WRITTEN NOTIFICATION: Conditions of License

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the condition of their license, regarding complying with an order that was issued.

Summary and Rationale
On January 18, 2024, the home was ordered to develop and implement a process for registered staff to follow when wound care supplies were not available to complete a resident's wound care treatments as ordered, and the process was to incorporate notification to the DOC and/or Skin and Wound Lead; notification to the resident's Physician and/or Nurse Practitioner, and corrective action that was to be taken to ensure that the required supplies were acquired in appropriate quantities in a timely manner. The home was also to develop and implement an auditing process for residents who had altered skin integrity, to ensure that their treatment orders were up to date and are being followed; the audits were to be completed weekly, for a minimum of four weeks. The compliance due date (CDD) was February 29, 2024.

The lead for the Skin and Wound program indicated that the home did not implement a progress to ensure that the NP or physician were made aware if supplies were not available and, that the home had not yet implemented audits to ensure that the residents wound care was being completed as per the physicians orders.

Sources: Two residents progress notes, and physicians orders; Licensee policy related to skin and wound; home's internal skin and wound, and supply tracking forms; interviews with a Registered Nurse (RN), NP, Skin and Wound Care Lead, and other relevant staff.

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An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
none

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments,

reassessments and interventions and that the resident's responses to interventions are documented.

1) The licensee has failed to ensure that triggers that were known for a resident were identified in the plan of care.

Rationale and Summary
A resident was known to display physically responsive behaviours towards other residents within the home area. A review of the plan of care did not identify any triggers related to the resident's responsive behaviours.

The Responsive Behaviour Lead reviewed the resident's plan of care and acknowledged that there were no triggers identified in the resident's plan of care and should have been.

There was risk to all residents as a result of identified triggers not being in the resident's plan of care.

Sources: A resident's progress notes and care plan; licensee policy titled "LTC Responsive Behaviour Program", last reviewed May 2023; and, interview with a PSW, Responsive Behaviour Lead, and other relevant staff.

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2) The licensee has failed to ensure that for a resident, who was demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours.

Rationale and Summary
A resident had a history of responsive behaviour and altercations with co-residents. Other residents' behaviours were identified as one of their triggers. The resident was assigned an intervention to redirect and keep them calm when they were triggered.

The assigned intervention was not implemented by a PSW.

The Behavioural Supports Ontario (BSO) lead acknowledged that staff did not follow the resident's plan of care for managing responsive behaviours.

Failure to provide the intervention for the resident as outlined in their plan of care in manage the known responsive behaviours, placed other residents at risk for harm and injury.

Sources: CI report, the resident's clinical records, the home's investigation notes; and interviews with a PSW, RN, agency staff, BSO lead, and other relevant staff

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3) The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A resident was to be assessed using a clinically appropriate tool after being involved in a resident to resident altercation.

A review of the clinically appropriate tool, showed missing documentation.

The BSO lead indicated that clinically appropriate tool for the resident was a component of their assessment and reassessment after altercation and helped determine their response to interventions.

Failure to complete charting for the resident when they demonstrated responsive behaviour may hinder their assessment and reassessment and staff's ability to evaluate resident's response to interventions.

Sources: The resident's charting; interviews with BSO lead, and other relevant staff. [741670]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary
During the inspection, three PSWs were observed entering residents' rooms without performing hand hygiene. Two other PSWs were also observed to have doffed used disposable gloves in the hallway and interacted with residents without performing hand hygiene.

The IPAC lead stated that staff should have performed hand hygiene after removing used gloves, and before interacting with residents and their environment.

Staff's failure to perform hand hygiene before resident and environment contact increased the risk of spreading infections in the home.

Sources: Inspector observations; interviews with PSWs, IPAC lead and other relevant staff.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that written responses provided to a person who made a complaint to the licensee concerning a resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
Written concerns regarding a resident, and an altercations with co-residents were received by the licensee, and the home responded to this concern in writing.

The response letters did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Failure to provide the MLTC and patient Ombudsman information to POA had low impact on the resident.

Sources: Review of CIS report and response letters ; and Clinical Manager/Interim Administrator.

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