



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

**Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486**

**Bureau régional de services de
Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486**

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 10, 2014	2014_298557_0001	T-433-13	Critical Incident System

Licensee/Titulaire de permis

**ORILLIA LONG TERM CARE CENTRE INC.
689 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

VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 3, 2014

During the course of this inspection, Inspector #557 was supervised by Inspector #110.

During the course of the inspection, the inspector(s) spoke with director of care (DOC), assistant director of care (ADOC), registered staff, personal support workers and residents.

During the course of the inspection, the inspector(s) review resident health care record, observed home area, residents and environment , staff resident interactions and provision of care

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Responsive Behaviours**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #1 is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing.

Resident #1 requires total care, by 2 staff, for all activities of daily living, including dressing. On an identified date, record review and staff interviews confirmed that Resident #1 was inappropriately dressed after being provided continence care in bed after lunch. Staff interviews revealed that resident fell asleep while continence care was provided and staff left resident sleeping, leaving the resident's pants below their knees with a blanket placed over the resident. Visitor walked into room and observed a resident trespassing in resident's room. Resident's blanket was no longer covering resident, leaving resident inappropriately dressed and exposed. The staff acknowledged that this was not appropriate care and was not a dignified way to leave a resident dressed while sleeping in the bed. [s. 40.]

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 to ensure Resident #1 is dressed as required and appropriately while in bed, to be implemented voluntarily.



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

Inspection Report under
the Long-Term Care
Homes Act, 2007

Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée

Issued on this 10th day of January, 2014

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

A handwritten signature in cursive script, appearing to read "Valerie Romanello".

