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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2016	2016_333577_0009	009083-14	Complaint

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

DEBBIE WARPULA (577), AMY GEAUVREAU (642), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 18-22 and 25-29, 2016.

The purpose of this inspection was to conduct a Complaint inspection related to seven complaints submitted to the Director: (#000797-14) regarding resident care, (#009083-14) regarding resident neglect and staffing, (#024133-15) regarding staffing and resident care, (#007344-14) regarding staffing concerns, resident care and equipment, (#030997-15) regarding plan of care, (#004256-15) regarding resident food and (#022187-15) regarding an outside provider.

This inspection was conducted concurrently with Critical Incident inspection #2016_333577_0008.

During the course of the inspection, the inspector(s) toured the resident care areas, observed the provision of care and services to residents, observed interactions between staff and residents, reviewed policies, procedures and programs, various health care records, schedules and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Staffing Coordinator, Personal Support Workers (PSWs), Dietary Aides, Housekeeping staff, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
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	Legendé 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. 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 was provided to the resident as specified in the plan.

In April 2016, Inspector #196 observed PSW #100 assist resident #048 with a pink coloured, thin textured beverage. The Dietary reference sheets were reviewed and identified "N" for the texture of fluids for resident #048. Dietary Aide #101 confirmed with Inspector #196 that the resident required a specific texture.

The Inspector spoke with PSW #100 regarding the texture of the beverage and they reported that the nurse had added fibre medication to the thickened milk which made the consistency thinner and confirmed that it was on the "thinner side".

The current care plan was reviewed and identified that resident #048 required special assistance for eating, had a medical condition which improved with thickened fluids and was to receive a specific texture.

An interview was conducted with RPN #102 and they reported that they had added liquid medication into the resident's milk and confirmed that the milk was no longer at the correct texture. [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 to ensure that the care set out in the plan of care is provided to resident #048 and all other residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (1) Subject to subsections (2) to (4), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage,
(a) the heating system; O. Reg. 79/10, s. 19 (1).
(b) emergency lighting in hallways, corridors, stairways and exits; and O. Reg. 79/10, s. 19 (1).
(c) essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment. O. Reg. 79/10, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was served by a generator that was available at all times and that has the capacity to maintain, in the event of a power outage, the heating system; emergency lighting in hallways, corridors, stairways and exits; and essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment.

During an interview on April 27, 2016, RPN #103 revealed to Inspector #196 that the home did not have a working generator.

An interview was conducted with the Environmental Services Manager (ESM) #104 and they confirmed that the annual service of the home's generator was completed on April 18, 2016, and the generator became inoperable on that date due to a need of parts. They further reported that the parts were expected to arrive on May 5 or 6, 2016.

An interview was conducted with the Administrator and they reported that at the time that the unit failed, April 18, 2016, approval of a rental unit was not approved by the licensee as there was a cost. [s. 19. (1) (a)]

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 that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage, the heating system; emergency lighting in hallways, corridors, stairways and exits; and essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment, to be implemented voluntarily.

WN #3: 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 has failed to ensure that each resident of the home was assisted with getting dressed as required, and was 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.

A complaint was received by the Director in March 2015, regarding concerns that residents in the home were inappropriately dressed in their pajamas for their supper meals.

On April 26, 2016, at 1600 hours, Inspector #642 observed residents #041, #042, and #043 on one of the home units seated in the hallway dressed in their pajamas. Observations made at 1640 hours, in a dining room revealed resident #045 and #046 dressed in their pajamas. Observations on another unit's dining room area revealed resident #006 dressed in a night gown.

Inspector #642 reviewed the care plans for residents #006, #041, #042, #043, #045, #046 and there was no indication of the residents' preference to be dressed in their pajamas before supper.

On April 29, 2016, at 0945 hours Inspector #642 interviewed the Director of Care (DOC) who confirmed that the residents should not be dressed in their pajamas before supper, unless it was their preference or if their power of attorney (POA) or substitute decision maker (SDM) requested it. [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 that residents #006, #041, #042, #043, #045, #046, and all other residents of the home are assisted with getting dressed as required, and are 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On April 26, 2016, at 1212 hours, during lunch service, Inspector #196 observed resident #049 to have slid down in their specialized chair as PSW #106 was assisting with their meal.

Inspector #196 confirmed with Registered Dietitian (RD) #107 that resident #049 was not seated upright in their specialized chair and not positioned correctly for their meal. The Inspector observed RD #107 and PSW #106 reposition the resident in a more upright position. [s. 73. (1) 10.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On April 26, 2016, at 1710 hours, during dinner service, Inspector #196 observed resident #050 seated at a dining table with a plate of food in front them. A PSW was present at the same table assisting two other residents while resident #050 was observed to reach out towards the plate of food with one hand. After eight minutes of observations, the Inspector noted RN #108 tell the PSW at the table to also assist resident #050 with their meal.

The Inspector reviewed the current care plan which identified that resident #050 required assistance from staff with their meals.

An interview was conducted with RN #108 who reported that the resident required full assistance with their meals.

An interview was conducted with the DOC on April 27, 2016, and they confirmed that residents were not to be served a meal until a staff member was available to assist the resident. [s. 73. (2) (b)]

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 that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, specifically in regards to resident #049 and all other residents; and to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, specifically in regards to resident #050 and all other residents, to be implemented voluntarily.

WN #5: 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, where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, was complied with. Specifically their written policies and protocols that were developed for the medication management system to ensure the accurate administration of all drugs used in the home was complied with.

On April 29, 2016, at 0915 hours, Inspector #196 observed pills on the table cloth in front of resident #047 and the resident moved the pills around on the table cloth and put them under the edge of the plate.

Inspector #196 alerted RN #109 to the pills on the table in front of resident #047, who then removed them and took them to the medication cart.

During an interview with RN #109 at 0925 hours, they reported that they had given the resident three medications in a cup prior to the resident going into the dining room.

RN #109 confirmed to the Inspector that it was the home's expectation that staff watch the residents take their pills when administering medications, and they should have observed resident #047 take their medication.

The current care plan for resident #047 was reviewed and did not include information that this resident could be left unattended with their medications.

The licensee's policy titled "Medication Management - Administration of Medications" revised date July 2015, was reviewed and it indicated that staff were to remain in attendance until the medication was taken.

During an interview with the DOC on April 29, 2016, at 1110 hours, they confirmed that registered staff were to ensure that residents take their medication at the time it was administered. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including, a breakdown of major equipment or a system in the home.

During an interview on April 27, 2016, RPN #103 revealed to Inspector #196 that the home did not have a working generator.

An interview was conducted with ESM #104 who confirmed that the annual service of the home's generator was completed on April 18, 2016, and the generator became inoperable on that date due to a need for parts.

An interview was conducted with the Administrator and they reported that at the time that the unit failed, April 18, 2016, they had not submitted a Critical Incident System report to the Director. [s. 107. (3) 2. ii.]

Issued on this 9th day of August, 2016

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

Original report signed by the inspector.