Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 11, 2011	2011_174_2835_11Jan10511	Complaint Log # T2977

Licensee/Titulaire
Orillia Long Term Care Centre Inc.
689 Yonge Street
Midland ON L4R2E1

Long-Term Care Home/Foyer de soins de longue durée
Leacock Care Centre
25 Museum Drive
Orillia ON L3V7T9

Name of Inspector(s)/Nom de l'inspecteur(s)
Nancy Bailey #174

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Registered Staff, PSW staff

During the course of the inspection, the inspector observed resident interactions, spoke with staff, conducted resident clinical record reviews

The following Inspection Protocols were used in part or in whole during this inspection:
Sufficient Staffing IP
Responsive Behaviour IP

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with Long- Term Care Homes Act S.O. 2007, c.8, s 3(1) 1
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c.8, s 3(1)1

Findings:

1. An RPN attempted to give a resident crushed medications in a spoonful of applesauce. Communication was not utilized to encourage the resident or tell her what the nurse was giving her, she continued to put the spoon to the resident's mouth with out explanation, despite the resident resisting by pushing her hand away, but the staff again pressed the spoon to the resident's mouth. When the resident raised her hand as if to hit the staff, the registered staff called to a PSW who then spoke to the resident and offered her a drink of water after which the resident took the medication off the spoon willingly.
2. An RPN administered a treatment to a female resident outside of the nursing station in the common sitting area in the presence of other residents. There was no provision of privacy offered to the resident.

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WN #2: The Licensee has failed to comply with Long term care Homes Act S.O. 2007, c.8, s 6(1)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. 2007, c.8, s.6(1)

Findings:

1. The plan of care for an identified resident does not identify triggers that the full time PSW staff verbalized during this inspection that must be utilized in the provision of care; This information is not in the plan of care for other staff members to use for consistent care to minimize responsive behaviours.
2. According to documentation from a physician during a recent assessment of an identified resident, "additional information was to be incorporated into the plan of care" as provided from the physician during the assessment, but the plan of care had not been revised other than this statement in the progress note.
3. The plan of care for an identified resident does not identify music therapy for the resident and when to use this form of therapy to minimize responsive behaviours. This information is documented in the psychogeriatric consult report, but has not been incorporated in to the plan of care for the staff providing care to the resident.

4. Following an aggressive episode the plan of care for an identified resident was not revised to include the potential for physical aggressions along with clear directions to staff that provide care to the resident.

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Additional Required Actions:
VPC- Pursuant to Long -Term Care Homes Act 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 plans of care for 3 identified residents, identify clear directions to staff and others who provide direct care to the residents.

WN #3: The Licensee has failed to comply with O. Regulation 79/10, 31(3)a The staffing plan must, provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

Findings:

- A total of 106 scheduled PSW shifts were either not replaced or only had part of the hours replaced during the time period from October 1 - December 31, 2010
- A total of 9 scheduled RN shifts and 18 scheduled RPN shifts were either not replaced or only had part of the hours replaced during the period of October 1 - December 31, 2010

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WN #4: The Licensee has failed to comply with O. Regulation 79/10, 53 (4)c
The licensee shall ensure that for each resident demonstrating responsive behaviours,
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.

Findings:

- Following the an aggressive incident between two identified residents, there was no documentation in the clinical records for the residents regarding interventions put into place for the safety of residents and the responses of the resident to the interventions.

Additional Required Actions:
VPC- Pursuant to Long -Term Care Homes Act S.O. 2007, c.8, s 152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that following a behavioural interactions between 2 identified residents, documentation in the clinical record identifies the interactions put into place and the resident's response to the interactions.
Written approaches

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 17/11