Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2020	2020_768693_0004	021127-19, 021553-19, 022366-19, 023864-19, 001778-20	Critical Incident System

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

MELISSA HAMILTON (693), JENNIFER LAURICELLA (542), LISA MOORE (613), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January, 20 to 24, and 27 to 30, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-two intakes, regarding alleged staff to resident neglect;
-two intakes, regarding residents taken to hospital and resulting in a significant change; and
-one intake, regarding alleged resident to resident abuse.

Complaint inspection #2020_768693_0003 and Follow Up inspection #2020_768693_0005 were conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (CDOC), Acting Staff Education Coordinator, Resident and Family Service Coordinator, Restorative Care Coordinator, Staff Education Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirement, unless contraindicated by a medical condition.

A Critical Incident (CI) report was submitted to the Director on an identified date for alleged staff to resident neglect. It was documented on the CI report that resident #001 had not been offered their bathing preference for an identified number of days.

Inspector #542 completed a review of resident #001's health care record. The care plan included documentation to indicate resident #001's bathing choice. The bathing assignment indicated that resident #001 was to receive their bathing choice on specified days of the week, at indicated times. It was documented in the progress notes on an identified date, that resident #001 was not bathed by the method of their choice. A review of the bathing/toileting audit tool from identified dates, revealed that resident #001 was not bathed by the method of their choice.

A review of the bathing/toileting auditing document was completed and showed that three additional residents were not bathed by the method of their choice, on the same home area where resident #001 resided (resident #012, resident #013 and resident #014).

Inspector #542 reviewed resident #012's health care record. It was documented in the progress notes that the resident was not bathed by the method of their choice on identified dates. The care plan for resident #012 indicated their bathing method of choice.

Inspector #542 reviewed resident #013's health care record. The care plan indicated the resident's bathing method of choice. In the progress notes it was documented on an identified date, that resident #013 was not provided with their bathing method of choice. On the bathing/toileting audit document, it also indicated that the resident was not provided with their bathing method of choice.

Inspector #542 reviewed resident #014's health care record. The care plan included that their bathing method of choice. A review of the progress notes and the bathing/toileting audit document indicated that on identified dates, resident #014 was not provided with their bathing method of choice.

Inspector #542 interviewed PSW #117, who indicated that when the bathing equipment was in disrepair, the staff were to bring the resident to another home area to ensure that

they were bathed by the method of their choice.

Inspector #542 completed an interview with RPN #118. RPN #118 stated that when bathing equipment was in disrepair the RPNs would instruct the PSWs to attempt another bathing method with the resident and if this was not possible, then they would need to use the bathing equipment on another home area.

Inspector #542 interviewed Staff Education Coordinator #120. A review of the progress notes and the bathing audit documents were reviewed by the Staff Education Coordinator #120 and this Inspector. They confirmed that residents #001, #012, #013 and #014, were not provided with the bathing method of their choice on the specific dates mentioned.

Inspector #542 conducted an interview with the DOC. They stated that resident #001 was not provided with their method of choice for bathing and was provided with another method of bathing a specific number of times during a an identified period of time. The staff should have completed the scheduled baths as required for all of the residents. [s. 33. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA HAMILTON (693), JENNIFER LAURICELLA (542), LISA MOORE (613), STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2020_768693_0004
Log No. / No de registre :	021127-19, 021553-19, 022366-19, 023864-19, 001778-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 5, 2020
Licensee / Titulaire de permis :	Orillia Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Leacock Care Centre 25 Museum Drive, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vittoria Trainer

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Orillia Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of the Ontario Regulation 79/10. Specifically, the licensee must:

a) Ensure that resident #001, #012, #013, and #014, and all other residents of the home are bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirement, unless contraindicated by a medical condition.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirement, unless contraindicated by a medical condition.

A Critical Incident (CI) report was submitted to the Director on an identified date for alleged staff to resident neglect. It was documented on the CI report that resident #001 had not been offered their bathing preference for an identified number of days.

Inspector #542 completed a review of resident #001's health care record. The care plan included documentation to indicate resident #001's bathing choice. The bathing assignment indicated that resident #001 was to receive their bathing choice on specified days of the week, at indicated times. It was documented in the progress notes on an identified date, that resident #001 was not bathed by the method of their choice. A review of the bathing/toileting audit

tool from identified dates, revealed that resident #001 was not bathed by the method of their choice.

A review of the bathing/toileting auditing document was completed and showed that three additional residents were not bathed by the method of their choice, on the same home area where resident #001 resided (resident #012, resident #013 and resident #014).

Inspector #542 reviewed resident #012's health care record. It was documented in the progress notes that the resident was not bathed by the method of their choice on identified dates. The care plan for resident #012 indicated their bathing method of choice.

Inspector #542 reviewed resident #013's health care record. The care plan indicated the resident's bathing method of choice. In the progress notes it was documented on an identified date, that resident #013 was not provided with their bathing method of choice. On the bathing/toileting audit document, it also indicated that the resident was not provided with their bathing method of choice.

Inspector #542 reviewed resident #014's health care record. The care plan included that their bathing method of choice. A review of the progress notes and the bathing/toileting audit document indicated that on identified dates, resident #014 was not provided with their bathing method of choice.

Inspector #542 interviewed PSW #117, who indicated that when the bathing equipment was in disrepair, the staff were to bring the resident to another home area to ensure that they were bathed by the method of their choice.

Inspector #542 completed an interview with RPN #118. RPN #118 stated that when bathing equipment was in disrepair the RPNs would instruct the PSWs to attempt another bathing method with the resident and if this was not possible, then they would need to use the bathing equipment on another home area.

Inspector #542 interviewed Staff Education Coordinator #120. A review of the progress notes and the bathing audit documents were reviewed by the Staff Education Coordinator #120 and this Inspector. They confirmed that residents #001, #012, #013 and #014, were not provided with the bathing method of their

choice on the specific dates mentioned.

Inspector #542 conducted an interview with the DOC. They stated that resident #001 was not provided with their method of choice for bathing and was provided with another method of bathing a specific number of times during a an identified period of time. The staff should have completed the scheduled baths as required for all of the residents.

The decision to issue a Compliance Order (CO) was based on the severity which indicated a minimum risk for actual harm to occur, and the scope, which indicated that the non-compliance was widespread. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation as follows:

- a Voluntary Plan of Correction (VPC) was issued from a Complaint Inspection #2019_752627_0016, on September 25, 2019;
- a VPC was issued from a Resident Quality Inspection (RQI) #2018_657681_0025, on December 28, 2018;
- a VPC was issued from a RQI #2017_486653_0019, on November 3, 2017; and
- a Written Notification (WN) was issued from a Complaint Inspection, on June 21, 2017.

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melissa Hamilton

Service Area Office /
Bureau régional de services : Sudbury Service Area Office