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

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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_0005	019038-19, 019039-19, 019040-19, 019041-19, 019042-19, 019043-19, 019044-19	Follow up

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 Follow up 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 Follow-Up inspection:
-one intake, related to CO #001 from inspection #2019_752627_0016, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7);
-one intake, related to CO #002 from inspection #2019_752627_0016, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 20. (1);
-one intake, related to CO #003 from inspection #2019_752627_0016, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24. (1);
-one intake, related to CO #004 from inspection #2019_752627_0016, issued pursuant to O.Reg 79/10, s. 50. (2);
-one intake, related to CO #005 from inspection #2019_752627_0016, issued pursuant to O.Reg 79/10, s. 229. (5);
-one intake, related to CO#001 from inspection #2019_752627_0015, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (10); and
-one intake, related to CO#006 from inspection #2019_752627_0016, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 19. (1).

Complaint inspection #2020_768693_0003 and Critical Incident System inspection #2020_768693_0004 were conducted concurrently with this Follow Up inspection.

A finding of non-compliance pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24. (1), from complaint inspection #2020_768693_0003 was issued in this report.

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:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #006	2019_752627_0016	542
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2019_752627_0016	542
O.Reg 79/10 s. 229. (5)	CO #005	2019_752627_0016	693
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2019_752627_0016	744
O.Reg 79/10 s. 50. (2)	CO #004	2019_752627_0016	693
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2019_752627_0015	693
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_752627_0016	613

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director, which indicated that a family member of resident #004, was not immediately notified of a resident to resident altercation involving resident #004 on an identified date.

Inspector #744 reviewed resident #004's electronic progress notes from an identified date, which indicated that RPN #103 had witnessed resident #004 in resident #007's bedroom. The progress note further indicated that RPN #103 overheard resident #004 speaking a specific phrase, and resident #007 responding. In addition the progress note identified that RPN #103 had witnessed resident #004 exhibiting a specified behaviour towards resident #007 and resident #004 was immediately redirected.

Inspector #744 reviewed the home’s policy, titled, “Resident Rights, Care and Services-Reporting and Complaints- Critical Incident Reporting”, last revised, March 15, 2019. The policy identified that the home shall ensure that the Ministry of Health is immediately informed if reasonable grounds exist to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

During an interview, the Administrator indicated that they were first made aware of the progress note outlining the incident from a specified date, during a morning manager’s meeting an identified number of days after the incident. The Administrator further indicated that they should have reported the incident immediately to the Director because of their initial suspicion of abuse and the risk of harm; however, an immediate report to the Director was not submitted.

Inspector #744 reviewed the Ministry of Long-Term Care's online Critical Incident System (CIS) reporting portal and determined that a Critical Incident report was submitted to the Director, for this incident, on an identified date, by the DOC.

CO #003 was issued during inspection #2019_7452627_0016 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, c.8, s. 24. (1) with a compliance due date of December 20, 2019. As the compliance date was not yet due at the time of this incident, this findings will be issued as a WN to further support the order. [s. 24. (1) 2.]

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.