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
May 14, 2021	2021_841679_0012	024374-20, 003631-21, 005271-21, 006915-21, 007015-21	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

MICHELLE BERARDI (679), AMY GEAUVREAU (642)

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): April 26-30, 2021. Additional off-site activities were conducted on May 3-4, 2021.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- One intake which was submitted to the Director for an allegation of resident to resident abuse;
- Two intakes which were submitted to the Director for allegations of improper care; and,
- Two intakes which were submitted to the Director for allegations of staff to resident abuse.

A Complaint Inspection #2021_841679_0010 and a Follow Up Inspection #2021_841679_0011 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-DOCs, Staff Educators, Housekeeping Supervisor, Culinary Manager, Restorative Care Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Community Support Worker for Specialized Geriatric Services, Administrative Assistant, Housekeepers, residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

7 WN(s)
5 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	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. 20. Policy to promote zero tolerance

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s policy to promote zero tolerance of abuse and neglect was complied with, with respect to an incident involving a resident.

The home’s policy titled “Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect” last revised June 30, 2020, indicated that staff members who had reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager was on site at the home. If the allegation of abuse or neglect was with the most senior administrative personnel (or the charge nurse if no manager is on-site at the home) the manager on-call was to be notified. The policy further indicated that the staff were to assess the resident to determine any injury and provide necessary care, assess the resident's condition, evaluating the safety, emotional and physical well-being of the resident, immediately remove the accused abuser from the resident and send the accused staff member home with pay pending completion of investigation.

A Critical Incident System (CIS) report was submitted to the Director related to an incident whereby a PSW had observed improper care of a resident. A review of a letter addressed to a Registered Nurse (RN) indicated that they had failed to follow the home’s Zero Tolerance of Abuse and Neglect policy, as they did not immediately remove the alleged person from the home, nor did they report the incident to the on call manager. In an interview with a Co-Director of Care (DOC), they indicated that registered staff were to immediately notify the on-call manager of the incident and send the accused staff member home, and that the RN did not send the staff member home, or contact the on-call manager.

Sources: CIS report; CIS investigation Notes; A resident’s medical records, including progress notes and assessments; Policy titled “Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect” last revised June 30, 2020; Interviews with a Co-DOC and other staff members. [s. 20.]

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 ensuring that the home's policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not restrained for the convenience of the licensee or staff.

A CIS report was submitted to the Director related to an incident whereby a PSW had observed an incident of improper care towards a resident involving a restraint.

A review of an interview transcript with a PSW indicated that they had applied the restraint to ensure that a resident remained in their room. In an interview with a PSW they indicated that at the time of the incident staff were encouraging the resident to stay in their room, and that they observed that a PSW had applied a restraint. In an interview with a Co-DOC they indicated that the home did not use restraints, and that staff were not permitted to use restraints to keep residents in their room.

Sources: CIS report; CIS Investigation Notes; A resident's medical records, including progress notes and assessments; Policy titled "Resident Rights, Care and Services- Consent- Restraints Policy" effective September 16, 2013; Interviews with a Co-DOC and other staff members. [s. 30. (1) 1.]

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 ensuring that no residents are restrained for the convenience of staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s continence plan was implemented.

A resident’s care plan indicated they were incontinent of bowel and bladder, and that the resident would request assistance as needed. In an interview with the resident, they indicated to the Inspector that there had been an incident involving staff. The Inspector reviewed the investigation notes regarding the incident which detailed that the resident had rang for assistance to receive continence care, and that they had to wait a period of time to receive their care. The resident reported that they felt negatively about the incident. In an interview with the DOC they indicated that continence care was not provided as per the resident's continence plan.

Sources: CIS report; A resident’s medical records: including progress notes and care plan; Interviews with a resident and the DOC; CIS investigation notes; Policy titled "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management- Program" last revised February 28, 2018” [s. 51. (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 ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowl and bladder continence based on that assessment, and that the plan is implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Inspector #679 requested a copy of the home's prevention of abuse and neglect program review for 2020. The Administrator indicated the home did not complete a review of the prevention of abuse and neglect program

Sources: Interview with the DOC and Administrator. [s. 99. (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 ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under s. 20 of the Act to promote zero tolerance of abuse and neglect of residents, including what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program was evaluated and updated at least annually in accordance with evidence-based practices, if there were none, in accordance with prevailing practices.

An interview with the Director of Care (DOC) and the Administrator identified they had not completed an annual review, and therefore were unable to provide a report of the IPAC program evaluation.

Sources: Interviews with the Administrator, and the DOC. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participated in the implementation of the IPAC program, related to hand hygiene.

The licensee's IPAC policy required staff to follow the "Just Clean Your Hands" (JCYH) program, and in this program was the requirement to clean residents hands before and after meals, snacks, and activities. The JCYH program also required staff to wash their hands in between resident care.

During observations of four dining services, the Inspector observed that staff were not washing their hands in between: resident care; after touching dirty dishes; and residents were not being assisted with performing hand hygiene after the meals were finished. A Personal Support Worker (PSW) stated that there was not a specific process in place to wash resident's hands before and after meals, that they did have yellow face clothes to wash the residents face and hands when they were soiled, but admits it does not always get done.

The Co-DOC/IPAC Lead acknowledged that the home's IPAC policy regarding hand hygiene should have been implemented, specifically the JCYH program. The Co-DOC/IPAC Lead also acknowledged that residents should have been assisted with hand hygiene before and after their meals, and the staff should be washing their hands in between resident care and handling of dirty dishes. The Co-DOC/IPAC Lead acknowledged the staff were not following their hand hygiene policy.

Sources: Observations of two lunch meals and one breakfast meal; interviews with the Co-DOC/IPAC Lead, a PSW and other staff; the home's policy, "Hand Hygiene Program" last revised 2020 and "Just Clean Your Hands" program resources. [s. 229. (4)]

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 ensuring that the Infection Prevention and Control (IPAC) program is evaluated and updated at least annually in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices; and, ensuring that staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #6: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the licensee had reasonable grounds to suspect that potential abuse had occurred the suspicion and the information upon which it was based, was immediately reported to the Director.

A review of a CIS report identified that a potential abuse incident had occurred on a specified date, and the report was submitted to the Director three days after the incident.

A review of a resident's progress notes identified that there were previous incidents which occurred between two residents.

An interview with the Administrator identified that the CIS report was submitted late.

Resources: CIS report; progress notes; Interview with the Administrator and other staff.
[s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written record was kept up to date at all times.

A CIS report was submitted to the Director related to an incident of improper care.

Inspector #679 reviewed a resident’s health records and identified that the progress note which detailed the incident was inputted three days after the incident. Additionally, the Inspector did not locate the completion of two required assessments related to the incident. In an interview with a Co-DOC, they indicated that incidents were to be documented in the resident’s chart, and that the two required assessments should be completed. Together, Inspector #679 and a CO-DOC reviewed the resident’s health records. The Co- DOC confirmed that the two required assessments were not documented and indicated the progress note was backdated because the staff member was asked to complete the proper documentation.

Sources: CIS report; CIS Investigation Notes; A resident’s medical records, including progress notes and assessments; Policy titled “Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect” last revised June 30, 2020; Interviews with Co-DOC #121, and other staff members. [s. 231. (b)]

Issued on this 18th day of May, 2021

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

Original report signed by the inspector.