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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159 Cedar Street Suite 403
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159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

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_0010	005080-21	Complaint

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 Complaint 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 intake was inspected upon during this Complaint Inspection:

- One intake related to resident care concerns.

A Follow Up Inspection #2021_841679_0011 and a Critical Incident System Inspection #2021_841679_0012 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:
Accommodation Services - Housekeeping
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was administered medications in accordance with the directions for use specified by the prescriber.

A resident was prescribed specified medications. Inspector #679 reviewed the resident's health care records which indicated a number of medications were not administered in accordance with the directions for use specified by the prescriber.

In an interview with a Staff Educator, they indicated that staff were to reference a residents electronic medication administration record (eMAR) to determine the medications that a resident required. The Staff Educator indicated that one of the resident's medications had specified directions, and that if staff were doing their proper checks, they would identify the specified instructions. Further, Inspector #679 and the Staff Educator reviewed the resident's medical records, and the Staff Educator confirmed they could not identify the administration of another medication.

Sources: A resident's medical records including: eMar, progress notes, physician orders; Interviews with a Staff Educator and other staff; Medication Incident Reporting form. [s. 131. (2)]

Additional Required Actions:

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

WN #2: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care for two residents when the care set out in the plan of care was not effective.

A resident was identified as experiencing multiple falls over a 10-month period. Inspector #679 reviewed the resident's medical records and identified that upon admission to the home, the staff had implemented two fall prevention interventions; however, after the implementation of the interventions staff had noted the interventions were not effective. The Inspector did not identify new approaches trialed to prevent falls until five months later. Further, a review of the post-fall assessment progress notes revealed that the section titled "plan to prevent further falls (new interventions)" was blank on a number of occasions. In an interview with the Restorative Care Coordinator (RCC), they indicated that the resident was provided with fall prevention interventions on admission, but staff soon identified that the interventions were not effective. When asked what new interventions were trialed to prevent falls, the RCC indicated they didn't believe that the home had trialed a lot of new interventions.

Sources: A resident's medical records including: progress notes, post-fall assessments, care plan; Inspector observations; Interviews with the Restorative Care Coordinator and other staff; the home's policy titled "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised May 7, 2019. [s. 6. (11) (b)]

2. A review of a resident's progress notes identified that they fallen numerous times over a specified period. A review of the most recent care plan identified that there was one intervention for fall prevention.

An interview with the Restorative Care Coordinator/Lead for the Falls Program identified that, the one intervention was implemented after a previous fall, and they had reviewed the recent post fall assessments and the care plan for the resident, and felt that the falls were related to other causes, and had not added any new interventions for the resident's falls.

Sources: A resident's progress notes, Fall/Post fall assessments; interview with Restorative Care Coordinator/Lead for Falls program and other staff. [s. 6. (11) (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 different approaches are considered in the revision of the plan of care when the care set out in the plan is not effective, to be implemented voluntarily.

WN #3: 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 the home's medication management policy was complied with.

Ontario Regulation 79/10 s. 114 (2) requires that the licensee has written policies and protocols for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the home's policy titled "Resident Rights, Care and Services- Medication Management" last revised March 03, 2020, which was part of the of the home's medication management system.

The home's policy titled "Resident Rights, Care and Services- Medication Management" last revised March 03, 2020, indicated upon identification of a medication error, the individual or registered staff identifying the incident were to initiate and complete the internal medication incident report. During a review of a resident's progress notes, multiple medication errors were noted (See WN #1 for further details). Inspector #679 requested a copy of the medication incident reports for the medication incidents, and the Director of Care (DOC) indicated that they had reviewed the medication incident forms, and the pharmacy's online reporting forms and could not locate the medication error forms for two of the identified errors. The DOC indicated the process for when a medication error was discovered included filling out a medication incident report, reporting to the resident's substitute decision maker (SDM), the physician and the pharmacy.

Sources: A resident's medical records including: physician orders, progress notes, medication administration record; Interviews with the DOC and other staff; Policy titled Resident Rights, Care and Services- Medication Management" last revised March 03, 2020. [s. 8. (1) (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 the home's written policies and procedures for the medication management system are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Ontario Regulation 79/10 s. 48 indicated that every licensee of a long-term care home shall ensure that the following interdisciplinary programs were developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and risk of injury.

Inspector #679 requested to review the falls prevention and management program review for 2020 from both the DOC and the Administrator. The Administrator indicated that the home did not complete the annual evaluation for the Falls prevention and management program.

Sources: Interview with the DOC and Administrator. [s. 30. (1) 3.]

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 falls prevention and management system is evaluated and updated at least annually in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

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.

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) :	MICHELLE BERARDI (679), AMY GEAUVREAU (642)
Inspection No. / No de l’inspection :	2021_841679_0010
Log No. / No de registre :	005080-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 14, 2021
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 :	Rhonda Murray-Collins

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. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that a resident's medications are administered in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

1. The licensee has failed to ensure that a resident was administered medications in accordance with the directions for use specified by the prescriber.

A resident was prescribed specified medications. Inspector #679 reviewed the resident's health care records which indicated a number of medications were not administered in accordance with the directions for use specified by the prescriber.

In an interview with a Staff Educator, they indicated that staff were to reference a residents electronic medication administration record (eMAR) to determine the medications that a resident required. The Staff Educator indicated that one of the resident's medications had specified directions, and that if staff were doing their proper checks, they would identify the specified instructions. Further, Inspector #679 and the Staff Educator reviewed the resident's medical records, and the Staff Educator confirmed they could not identify the administration of another medication.

Sources: A resident's medical records including: eMar, progress notes, physician orders; Interviews with a Staff Educator and other staff; Medication Incident Reporting form.

An order was made by taking the following factors into account:

Severity: Minimal risk was identified related to the staff not administering a resident's medications as per the directions specified by the prescriber.

Scope: The scope of this non-compliance was a pattern, as it related to a number of medication errors noted for the resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with Ontario Regulation 79/10, s. 131. (2) and two VPCs were issued to the home.
(679)

Ontario

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Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 31, 2021

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 14th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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