Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965
sudburysao.moh@ontario.ca

Original Public Report

Report Issue Date: December 28, 2022
Inspection Number: 2022-1320-0003
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Orillia Long Term Care Centre Inc.
Long Term Care Home and City: Leacock Care Centre, Orillia

Lead Inspector	**Inspector Digital Signature**
Shelley Murphy (684)	Shelley Murphy Digitally signed by Shelley Murphy Date: 2022.12.29 14:30:58 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12-16, 2022

The following intake(s) were inspected:
Four intakes related to resident to resident sexual abuse;
One intake related to Improper/incompetent care of resident;
One intake related to a skin and wound complaint; and,
• One Intake related to Compliance Order (CO) #001, issued in report #2022-1320-0002, related O.Reg. 246/22, s. 79 (1) 4 regarding dining and snack with a compliance due date (CDD) of November 25, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1320-0002 related to O.Reg. 246/22, s. 79 (1) 4. inspected by Shelley Murphy (684)

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Skin and Wound Prevention and Management
Admission, Absences and Discharge
Pain Management
Responsive Behaviours
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: s. 6 (7)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to two residents, as specified in their plans.

1) During a review of Critical Incident System Report it was noted that one resident received an incorrect intervention. Upon review of the resident's chart, it confirmed the resident had an incorrect intervention. Personal Support Worker (PSW) was interviewed and acknowledged they used an incorrect intervention.

The risk to the resident as it related to this non-compliance was moderate.

Sources: CIS Report ; The resident's chart; the Home's policy "Plan of Care (Care Planning)" last reviewed June 3, 2022; and PSW interview.

2) CIS Report, was reviewed and it stated that a resident's care plan was reviewed and updated. Upon reviewing the resident's care plan, it specified a certain intervention that was to be in place.
On two separate dates, the inspector noted that the specific intervention was not implemented for the resident. This was confirmed by a PSW , and Registered Practical Nurse (RPN). The Director of Care

(DOC) indicated that it was the expectation that the intervention be implemented for the resident.

The risk to the resident as it related to this non-compliance was low.

Sources: CIS report; Resident's care plan; Observations of the resident; the Home's policy "Plan of Care (Care Planning)" last reviewed June 3, 2022; and PSW, RPN and DOC interviews.
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