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

Original Public Report

Report Issue Date: January 19, 2024

Inspection Number: 2023-1320-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Orillia Long Term Care Centre Inc.

Long Term Care Home and City: Leacock Care Centre, Orillia

Lead Inspector	**Inspector Digital Signature**
Jennifer Nicholls (691)	Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2024.02.06 12:18:22 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6- 10, November 14, 16, 17, and November 20-22, 2023. The inspection occurred offsite on the following date(s): November 15, 2023

The following intake(s) were inspected:

- One Intake related to a fall of a resident resulting in injury.
- Two complaint Intakes related to improper/ incompetent care of a resident.
- One intake related to Improper/incompetent care of resident
- One Intake was related to an allegation of abuse of residents by a staff member.
- One intake was related to unexpected death of a resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Substitute Decision Maker Involvement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

Involvement of resident, etc.

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was given the opportunity to fully participate in the resident's plan of care.

Rationale and Summary
The home received a written complaint regarding an allegation of improper care and the lack of communication between the home and the resident's SDM.

Documentation identified that the updates to the SDM did not include relevant information that reflected the resident's current condition or need for further treatment or testing.

The Administrator confirmed that the home did not provide the SDM with an extensive explanation that reflected the current condition of the resident to allow them to fully participate in the plan of care.

There was minimal risk and impact to the resident when the home did not provide the SDM an explanation of the care plan as the home continued with the prescribed treatment.

Sources: A resident's health care records; the home's investigation file; complaint letter and response letter to SDM/family member; Interviews with Administrator, Director of Care (DOC) and other staff.

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WRITTEN NOTIFICATION: Food Production

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and

The licensee has failed to comply with the home's food production system.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is an organized food production system to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) to preserve taste, nutritive value, appearance and food quality, and this system is complied with.

Specifically, staff did not comply with the policy dated February 2022 "LTC Between Meal Snacks" implemented by the licensee that stated to ensure that special items were labeled with the resident's name and room number and dated to assist with distribution.

Rationale and Summary
A resident received a specialized dietary item that did not appear to be the appropriate appearance and was incorrectly labelled.

The home identified that they failed to follow the home's food production policy and procedure.

There was minimal risk to the resident as the specialized item was not expired.

Sources: The home's policies titled "LTC Between Meals Snacks", last revised February 2022, Complaint / Concern log and investigation notes; and Interviews with PSW; FSM; Dietary Staff, and the Administrator.

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WRITTEN NOTIFICATION: Symptom monitoring with presence of Infection

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to monitor every shift, a resident who had indications of the presence of infection.

Rationale and Summary

A resident was noted to have signs and symptoms of infection. Review of the progress notes revealed that infection monitoring assessments, including vital signs, were not regularly documented every shift during the infectious period.

A Registered Nurse (RN) indicated the process of the home is to assess the resident every shift, and to document that assessment in Point Click Care (PCC) when the resident had signs or symptoms of infection.

The DOC indicated the expectation of staff would have been to complete an infection monitoring note every shift during the suspected or confirmed infection.

The irregular assessment documentation placed the resident at increased risk for potential complications of the infection.

Sources: A resident's progress note, and assessments in PCC; interviews with an RN, and DOC: licensee policy tilted "LTC Infection Prevention and Control Surveillance Policy" last revised July 2023.

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WRITTEN NOTIFICATION: Managing Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that the complainant received a response, explanation and resolution regarding their concerns brought forward regarding a resident.

Rationale and Summary
A review of the home's internal complaint logs identified that the SDM of a resident had expressed concerns regarding multiple care issues from an identified time period.

A) One log identified the home received a written complaint by the SDM of a

resident regarding care concerns. A review of the investigation notes indicated that an investigation was initiated, and completed by the home, although no documentation was identified with any follow up or explanation between the home and the complainant.

B) One log identified the home received a subsequent written complaint from the SDM of a resident which requested follow up from the original concern previously dated, as well further concerns care concerns. A review of the progress notes, as well as the internal investigation logs of these concerns identified that the home completed an investigation, but failed to provide the SDM with an explanation of the outcome of the investigation or provide resolution within an appropriate time frame as required.

The Administrator identified that the complaints follow up process was not followed to provide an explanation, regarding resolution or outcome of investigation to the concerns brought forward by the SDM of the resident.

There was minimal risk to the resident as the concerns regarding the complaint was investigated even though the complainant was not followed up with.

Sources: Internal email communications; complaints binder; investigation packages; Critical Incident System (CIS); licensee's policy titled "Concerns and Complaints Management, last reviewed June 2022; and interview with the Administrator, DOC, and other relevant staff.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee has failed to comply with s. 55 (2) (b) (ii)

The licensee shall:

a) Develop and implement a process for registered staff to follow when supplies for altered skin integrity are not available to complete a resident's treatments as ordered. The process must incorporate the following parameters:
- notification to the DOC and/or alternate.
- notification to the resident's Physician and/or Nurse Practitioner.
- corrective action that will be taken to ensure that the required supplies are acquired in appropriate quantities in a timely manner.

b) Develop and implement an auditing process for residents who have altered skin integrity, to ensure that their treatment orders are up to date and are being followed. The audits are to be completed weekly, for a minimum of four weeks. Documentation of the audits, as well as, any corrective action taken by the home to address deficiencies, must be maintained.

Grounds
The licensee has failed to ensure a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Summary and Rationale

a) An order was given for a resident to receive a specialized treatment intervention on an identified date.

Documentation in the progress notes identified that the resident did not receive the specialized treatment intervention until a specified date, weeks later.

The Administrator reviewed the resident's progress notes and identified that the resident did not receive the specialized treatment order in a timely manner; therefore immediate treatment or intervention was not provided.

There is high risk to the resident due to the delay in immediate delivery of the specialized treatment as this put the resident at risk for infection and worsening skin integrity.

Sources: A resident's care plans, physician/NP orders, progress notes; interviews with Administrator, and other staff.

b) A resident was ordered to have specialized treatment; however, a progress note indicated that an alternate treatment was given; as the ordered treatment was not available. Registered Nurse's (RNs), and other staff, further indicated that there was ongoing concern with access to adequate specialized treatment as ordered, therefore they had to use alternate protocols.

The (DOC) indicated that the expectation would be that the appropriate ordered treatments supplies would be available as required. The DOC acknowledged that when supplies were not available as ordered, the staff were not able to provide the prescribed immediate treatment and interventions.

The home's failure to ensure that ordered specialized supplies for immediate treatment and interventions to promote healing, and prevent infection, as required, presented a high risk of harm to residents care for by staff.

Sources: A resident's care plans, physician/NP orders, progress notes; interviews with RNs, as well as the DOC, and other staff.

This order must be complied with by February 29, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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