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: August 2, 2024
Inspection Number: 2024-1320-0003
Inspection Type: Critical Incident Follow up
Licensee: Orillia Long Term Care Centre Inc.
Long Term Care Home and City: Leacock Care Centre, Orillia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-28, 2024.

The following intake(s) were inspected:

- Seven intakes, related to resident abuse, resident-to-resident physical aggression; and,
- Intake, regarding Follow-up to compliance order (CO) # 2, related to the homes Skin and Wound Program.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1320-0007 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by Shannon Russell (692)

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
(a) The home's incident reports indicated that following resident-to-resident altercations, wherein a resident had exhibited an inappropriate act towards three different residents, on four separate occasions, a specified assessment was to be completed as part of the home's response to the incidents. The specified assessment was commenced for one resident; however, the assessment was not completed. The assessment was not initiated for the other three incidents involving the same resident. The inspector was unable to locate any documentation related to

the identified assessment, or related support provided to the three residents following the reported incidents.

The home's policy titled, "LTC Abuse – Zero Tolerance Policy for Resident Abuse and Neglect", stated the Resident Family Service Coordinator (RFSC) would provide ongoing support and assistance to the resident who had been abused, or allegedly abused. The policy also stated the home was required to ensure the incident, resident assessment, and all conversations including, but not limited to, the resident were documented.

The RFSC confirmed they received the referral to complete the specified assessment for one of the residents, and recalled seeing the resident; however, acknowledged they did not document the interaction within the referral, or elsewhere in the resident's health care chart, and should have. The RFSC identified that they had not received the referrals for two incidents involving one resident or for the incident involving the third resident, and they should have.

The home's Administrator confirmed the specified assessments were not completed for the three residents, and based on the documentation could not confirm that the residents had received support following the physical altercations with resident exhibiting responsive behaviours towards them.

(b) A specific assessment was initiated for a resident after exhibiting a specific responsive behaviour towards another resident. A review of the specific assessment revealed four sections of the assessment were not completed.

An Registered Nurse (RN) acknowledged that if the specific assessment was not completed in full it would not provide all the information required to determine the resident's status following an incident. The Administrator confirmed the specific

assessment was not completed for the resident and indicated it should have been.

There was low risk to the residents when the required assessments were not completed and when the RFSC did not document the follow up, or complete the assessments related to the support that was provided to the residents following the physical altercations on the identified dates..

Sources: Three CI reports; the home's investigation notes, progress notes and assessments for three residents; The home's policy titled, "LTC Abuse – Zero Tolerance Policy for Resident Abuse and Neglect", effective 16/09/2013, last revised 05/07/2022; interviews with residents, RFSC, the Administrator, and other staff.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
1. Review the plan of care for the identified residents, to ensure all demonstrated responsive behaviours, and any known triggers are identified on the care plan and kardex. Ensure that strategies to respond to the responsive behaviours are clearly outlined on the care plan and kardex.

2. Ensure all Registered and direct care staff that provide care to the identified residents, are made aware of the changes to the care plan and kardex.

3. Complete a documented review of the one-to-one resident monitoring process to ensure that all staff providing one-to-one resident monitoring are aware of their roles and responsibilities, including the hand off process for shift change and staff breaks. The record of the names participated in the review, the contents of the information identified, the date completed, and who provided the review, is to be maintained and provided to the Inspector upon request; and,

4. Develop and implement an auditing process for residents exhibiting responsive behaviours to ensure the plan of care is up to date including:
-behaviours, triggers, and strategies to manage those behaviours are identified,
-that one-to-one staff are completing the duties as required,
-referrals, assessments and DOS charting are completed and documented within the resident's health care records as indicated.
The audits are to be completed for a period of four weeks and is to include any actions taken if deficiencies are noted, the date of the audit, and who completed the audit.

Grounds

The licensee has failed to ensure that when three resident's exhibited responsive behaviours towards other residents, strategies were developed and implemented to respond to the behaviours and, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

Rationale and Summary

1. (a) A resident had begun demonstrating responsive behaviours towards another resident, and had verbalized to staff on three consecutive days that they were going to continue to exhibit a specific responsive behaviour towards the same resident.
(b) The resident's progress notes and documentation from staff monitoring the resident, indicated that the resident had been exhibiting specific responsive behaviours towards staff and co-residents.

(c) The resident had a history of responsive behaviours and had a specific monitoring process implemented for a period. A review of the monitoring records identified that there were several occasions where there was no documentation completed.

The resident's care plan and Kardex did not contain any information related to the identified responsive behaviours, or any identified interventions to manage the responsive behaviour until after the inspector interviewed staff, and the Responsive Behaviour Lead.

Direct care staff and registered staff stated that the resident frequently exhibited the specific responsive behaviours. The Lead for the Responsive Behaviour program confirmed that there was no information on the care plan or Kardex, and that there were no interventions in place to address the specified responsive behaviours.

Registered staff, the Responsive Behaviour Lead and the Administrator stated that when a resident had a specific intervention in place, staff were to complete the monitoring process for the entirety of the period, and that the documentation should be fully completed with no gaps.

There was a moderate risk to residents related to not having identified the responsive behaviours of the resident, and not including strategies and interventions to manage the behaviours and mitigate risk to other residents.

Sources: A resident's health care records; interviews with direct care staff, registered staff, the Responsive Behaviour Lead, and the Administrator. [690]

2. (a) A different resident had a history of specific responsive behaviours towards co-residents. The care plan and Kardex did not have any information related to their responsive behaviours towards co-residents, or any strategies identified to manage the responsive behaviour. Progress notes identified that the resident had an identified intervention in place and when it was discontinued on an identified date, there were no alternative interventions implemented to address the responsive behaviours towards co-residents.

(b) The resident's progress notes identified occasions where the resident was exhibiting a specific responsive behaviour, resulting in a trigger for co-residents' behaviours. The care plan and Kardex had not included interventions to manage the behaviour.

(c) The resident had a history of exhibiting a specific responsive behaviour, and the registered staff were to perform a check of the resident's room on every shift due to the exhibited behaviour.

(d) The resident had a monitoring process implemented, which a review of the monitoring records identified that there were several gaps where there was no documentation during the period of time required.

Direct care staff confirmed that there was no information, or any interventions identified on the care plan or Kardex related to the behaviours. Registered staff, the Responsive Behaviour Lead and the Administrator all confirmed that this information should have been included in the care plan and Kardex to address the responsive behaviours towards co-residents. As well, they stated that when a resident had the specified monitoring process in place, the charting was to be completed and that the documentation should have been fully completed with no gaps.

There was a moderate risk to residents related to not having identified the responsive behaviours of the resident, and not including strategies and interventions to manage the behaviours and mitigate risk to other residents.

Sources: A resident's health care records; interviews with PSW staff, Registered staff, the Responsive Behaviour Lead, and the Administrator.

3. (a) The documentation for another resident indicated that a specified monitoring process was to be completed for a specific timeframe for the resident. Review of monitoring documentation for the identified period, revealed that documentation was missing for significant time periods on all the identified dates, as well as surrounding dates.

Multiple staff, including the Administrator confirmed that the monitoring charting was expected to be completed in full. A Co-Director of Care (Co-DOC) acknowledged the monitoring charting was not completed in full for the resident and should have been.

(b) At the time of the inspection, the resident's plan of care detailed that the resident was to have a specific intervention in place to manage their responsive behaviours. As well, it contained details of the resident requiring specific assistance for personal care need; however, there was a documented behavioural intervention, of providing all care by an alternative assistance level.

Throughout the inspection, the resident was observed as having a specific intervention and with a specific level of assistance. Multiple staff and a Co-DOC confirmed that the resident had the intervention and level of assistance as observed by the Inspector. A Co-DOC acknowledged the resident's plan of care was not updated in relation to the level of supervision the resident required and acknowledged that the care plan could have been clearer for staff related to the resident's care needs.

(c) The resident's plan of care indicated that the resident was to always have a specified intervention in place.

The Inspector observed on two separate dates the resident in close proximity of co-residents without the specified intervention in place.

Multiple staff indicated that the resident required the specified intervention to be in place at all times, due to the resident's responsive behaviours and acknowledged if the specified intervention was not in place, it would pose a risk. The Director of Care (DOC) confirmed the resident should have had the specified intervention in place at all times.

There was moderate risk to all residents when the licensee failed to ensure strategies were implemented to respond to the resident's responsive behaviours and that actions were taken to respond to the residents needs and that those interventions were documented. There was harm to residents when the resident exhibited the responsive behaviours towards them.

Sources: Inspector observations; residents health care records; three CI reports; the home's policy titled, "LTC Responsive Behaviour Program", effective 16/09/2023; health care records for a resident; and interviews with a resident, a Co-DOC, the Administrator, and other staff.

This order must be complied with by September 20, 2024.

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s.

155 of the FLTCA, 2021, and / or s. 153 of the LTCHA, 2007.
This was the second follow up for the issued compliance order.
Compliance Order #001 from Inspection #2023-1320-0007 related to O. Reg. 246 / 22, s. 55 (2) (b) (ii). This was the second follow up for the issued compliance order.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.