Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 8, 2013	2013_109153_0018	T-313-13, T-318-13,T-325-13	Complaint

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 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

LYNN PARSONS (153)

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): July 4, 5, 8, 9, 10, 17, 18, 2013.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Co-Director of Care, Staff Educator, Environmental Manager, Registered Practical Nurses(RPNs), Personal Support Workers(PSWs), Residents and Families.

During the course of the inspection, the inspector(s) reviewed clinical health records, staff schedules, training records and home policies related to Abuse, Responsive Behaviors and Medication Administration System.
Completed observations of staff to resident interactions, resident to resident interactions and information posted throughout the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure the written plan of care set out clear direction to staff and others who provide direct care to the resident.
The written plan of care for Resident # 1 from May 23, 2013 to present indicates the home is trialing the use of a CD walk man playing soft music when the resident is sitting at the nurses station in a wheel chair to minimize agitation caused by high traffic at the nurses' station.
Observations completed throughout the inspection failed to confirm this intervention was in place.
When interviewed the Co-Director of Care indicated this intervention was discontinued due to an increased level of agitation experienced by Resident #1.
The Co-Director of Care confirmed the written plan of care did not provide clear direction and the noted intervention should have been removed when the intervention was discontinued. [s. 6. (1) (c)]

2. The behavioral plan of care for Resident # 2 indicates interventions to reduce wandering include the following;
- post a sign on room door with resident's name.
- post a sign on the door to the bathroom with the words "washroom".
A review of the written plan of care for Resident # 2 indicated that it does not include the above noted interventions.
Interview with the Co-Director of Care confirmed the written plan of care does not provide clear direction related to interventions in place. [s. 6. (1) (c)]

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 to ensure the written plans of care provide clear direction to the staff and others who provide direct care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.
The home's Zero Tolerance Policy for Resident Abuse revised January 2013 includes the following information:
- Staff member who has reasonable grounds to suspect abuse of a resident must immediately report his/her suspicion to the most senior administrative personnel on site at the Home.
- Qualified staff member who has reasonable grounds to suspect abuse of a resident should assess the resident and provide any necessary care.
- The most senior staff member (or designate) who receives a report of resident abuse will:
a) Assess the resident to determine any injury and provide necessary care
b) Immediately remove the accused abuser from the resident
c) Send an accused staff member home with pay pending completion of investigation
d) Promptly notify the Administrator and/or Director of Care of the alleged incident of abuse
e) Commence a preliminary investigation.

On an evening shift a PSW verbally reported an allegation of physical abuse to an identified RPN whereby an identified PSW struck Resident # 5 while providing care.The RPN indicated she would speak to the identified PSW about the reported incident.
The RPN did not complete the following actions as identified in the home's policy:
- Assess the resident to determine any injury and provide necessary care
- Immediately remove the accused abuser from the resident
- Send the accused staff member home with pay pending completion of investigation
- Promptly notify the Administrator and/or Director of Care of the alleged incident of abuse
- Commence a preliminary investigation.

On the following day the PSW who verbally reported the incident the evening before gave the identified RPN a written statement of the events that occurred during the previous evening.

The PSW who reported the allegation arrived on site for an evening shift two days later and was surprised to find the identified PSW at work.
The PSW who reported the incident spoke to the RPN who indicated she had not

spoken with the identified PSW.
The PSW who witnessed and reported the incident then notified management.

When interviewed the identified RPN indicated she did not have time to speak with the identified PSW and did not submit the written statement to Management until they came to her requesting to see it after an investigation was initiated.
When interviewed the Co-Director confirmed the identified RPN should have reported the allegation immediately to management. [s. 20. (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 to ensure the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

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1. The licensee did not ensure that every alleged incident of abuse that is reported is immediately investigated.
Resident # 6 reported an allegation of sexual abuse whereby Resident # 2 touched Resident # 6's breast.
A review of the progress notes revealed a late entry which was created after the inspector requested information on the home's investigation into the allegation.
The late entry progress note indicated Resident # 6 did not mention to RPN or PSW about the incident. "Resident showing no recollection of the incident".
When interviewed the Co-Director of care confirmed the allegation of sexual abuse was not immediately investigated. [s. 23. (1) (a)]

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 to ensure every alleged incident of abuse that is reported is immediately investigated, to be implemented voluntarily.

WN #4: 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 did not immediately report allegations of abuse to the Director.
A PSW reported an allegation of physical abuse whereby an identified PSW struck Resident #5 in the leg.
During an interview with the Co-Director of Care it was identified the allegation of physical abuse was not immediately reported to the Director.

Resident # 6 reported an incident whereby Resident # 2 wandered into the resident's room and inappropriately touched Resident #6's breast.
During an interview with the Co-Director of Care it was identified the allegation of sexual abuse was not immediately reported to the Director. [s. 24. (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 to ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee did not ensure screening measures which include criminal reference checks on persons 18 years of age and older.
A review of files for staff hired within the last 4 months revealed 3 identified nursing staff and 1 identified program staff did not have criminal reference checks in place.
All of the staff have worked scheduled shifts prior to this inspection.
When interviewed the managers confirmed a completed vulnerable sector screening had not been received for the identified staff. [s. 75. (2)]

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 to ensure criminal reference checks have been conducted on individuals 18 tears of age or older, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the building, including both interior and exterior areas are maintained in good repair.
The Activity Room on Resident Home Area 4 has been out of service since February 2013 due to significant damage in the ceiling as a result of a leak in the roof.
As of July 10, 2013 the Activity Room remains inaccessible to residents for programming activities despite the completion of roof repairs on May 15, 2013.
When interviewed the Environmental Services Manager confirmed the Activity Room was closed when he commenced his duties on February 28, 2013.
The Administrator confirmed when interviewed quotes have been received for the repairs which will be scheduled as soon as possible. [s. 90. (1) (a)]

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 to ensure the Activity Room on Resident Home Area 4 is repaired and placed in service as soon as possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that drugs are stored in an area that is secure and locked.
On July 10, 2013 at 09:50h a nursing cart was observed sitting in the hallway outside a resident's room on Resident Area 5 unattended containing a basket of prescription creams.
There were no staff in the area.
This resident area has several residents who wander in and out of resident rooms.
It was reported to the RPN who came and removed the basket with the prescription creams and placed them in the medication room. [s. 129. (1) (a) (ii)]

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 to ensure that drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure there is a documented quarterly reassessment of each resident's drug regime.
The quarterly reassessment of Resident #2's drug regime for the period of May 1 - July 31, 2013 was not documented when reviewed on July 12, 2013.
When interviewed the Co-Director of Care confirmed the reassessment had not been completed by the physician. [s. 134. (c)]

Issued on this 13th day of August, 2013

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

Lynn Parsons