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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Jun 17, 2014	2014_108110_0008	T-435-14	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

DIANE BROWN (110), JANICE PITTS ()

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): May 16, 23, 26-28, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, registered dietitian, continence care lead, registered staff, acting director of care, acting co director of care, staff educator, nurse practitioner, housekeeping aide, personal support workers, residents.

During the course of the inspection, the inspector(s) reviewed resident health records, bathing schedules, observed resident home area environment.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other.

Resident #001 was provided bowel interventions without staff collaboration.

Record review identified resident #001 at high risk for constipation.
On an identified date, the nurse practitioner (NP) assessed resident #001's constipation and ordered treatment once daily for 2 days and to report the effect.

Record review and staff interviews revealed that on an identified date, the NP followed-up and spoke with a registered staff who reported that the treatment the NP ordered five days prior was not given. The NP wrote additional orders for constipation on an identified date, with the understanding that the treatment ordered five days ago had not been given. On the same identified date, a registered staff initiated giving resident #001 a treatment for constipation with the understanding that the previous order for this treatment was not carried out. Upon further investigation, a review of the (medication administration record) MAR and staff interviews confirmed that the resident did receive the initial treatment ordered by the NP on two identified dates. [s. 6. (4) (a)]

2. There was no collaboration related to resident #001's order for dietary interventions.

Record review identified that resident #001 was assessed by the NP on an identified date, related to constipation. A dietary order was written by the NP to increase fluids,

prune juice, veggies and fruit for the resident. Record review and an interview with the registered dietitian confirmed that he/she or the dietary department were not notified of the dietary order and that no assessment or implementation of dietary interventions were carried out. On an identified date, the NP ordered a treatment for constipation and further bowel interventions. [s. 6. (4) (a)]

3. The care set out in the plan of care was not provided to the resident #001 as specified in the plan.

Resident #001 was at high risk for constipation. Resident #001's plan of care, included an NP order for staff to "report the effect" of a treatment ordered once a day for two days on an identified date. Record review and staff interviews revealed that there was no reporting of effect of the treatment administered on two identified dates.

Record review on an identified date, included a NP verbal order for resident #001 which included administering treatment A first and treatment B if treatment A had no effect. An interview with the registered staff and record review revealed that the resident did not require a specific intervention indicated in the NP"s verbal order, however, a registered staff directed a nursing student to administer treatment B to resident #001 under his/her supervision contrary to the NP order which indicated to administer treatment A first. [s. 6. (7)]

4. Resident #001's plan of care required resident to receive a medication, three times daily by mouth at 8 am, 4 pm, and 8 pm. Record review and staff interviews revealed that on an identified date, the resident was given his/her 4 pm dose at 12 pm contrary to physician orders and resident's plan of care. [s. 6. (7)]

5. Resident #001's plan of care required a therapeutic shampoo and a bath treatment to be used twice a week. Record review and staff interviews revealed that the resident did not receive this treatment twice a week over a 10 day period. [s. 6. (7)]

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 staff collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other that care set out in a resident's plan of care is provided to the resident as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Record review and an interview with resident #004 identified that resident's scheduled bath on Sunday of an identified date, was not provided and that the unit was short staffed. Monday, the following day, a PSW revealed that resident #004 had asked staff if he/she was being bathed today as he/she had not been bathed on Sunday. Resident was not bathed until four days later, his/her next regularly scheduled bath day. Further review identified that resident #004 was not offered a bath on the previous Thursday. A progress note in resident's health record stated that staff were not able to give a bath in the morning due to time constraints. Record review and interviews confirmed that resident #004 had not been bathed for over a 10 day period, and not bathed, at a minimum, twice a week.

Resident #005's plan of care required the resident to be bathed on Sunday and Wednesday of each week. Resident's plan of care stated to ensure the hair is washed on the bath day. Record review and interviews confirmed that resident #005 had not been bathed with hair washed for a 9 day period and not bathed, at a minimum, twice a week.

Resident #007's plan of care required the resident to be bathed on Sunday and Thursday of each week. Record review and interviews confirmed that resident #007 had not been bathed for a 13 day period and not bathed, at a minimum, twice a week. [s. 33. (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 that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: 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 failed to ensure that when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs.

Resident #001 was prescribed an identified medication, three times daily by mouth at 8 am, 4 pm, and 8 pm. On an identified date, the resident was complaining of pain and the RPN gave resident's 4 pm dose of his/her prescribed medication at 12 pm for pain.
An interview with the RPN confirmed that documentation of the effectiveness of the medication is to be completed in the progress notes. A review of the progress notes and an interview with the ADOC confirmed that there was no documentation in the progress notes related to resident #001's response or the effectiveness of the medication given at 4 pm.

Resident #001 was prescribed, by the nurse practitioner, a treatment to be given once a day for two days on an identified date. Record review and staff interviews revealed that treatments were given on the evening shifts on 2 identified dates, however, no documentation in the progress notes related to resident #001's response or the effectiveness of the treatment was completed. An interview with the nurse practitioner revealed that when he/she followed-up five days later, he/she reviewed the progress notes and noted there was no documentation on the effect of the treatment. Interviews with registered staff confirmed that documentation of the effectiveness of the treatment was to be completed in the progress notes. [s. 134. (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 that when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs, to be implemented voluntarily.

Issued on this 20th day of June, 2014

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