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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 16, 2015	2015_417178_0004	T-1745-15	Resident Quality Inspection

Licensee/Titulaire de permis

848357 ONTARIO INC.
33 Christie Street TORONTO ON M6G 3B1

Long-Term Care Home/Foyer de soins de longue durée

THE O'NEILL CENTRE
33 CHRISTIE STREET TORONTO ON M6G 3B1

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

SUSAN LUI (178), ARIEL JONES (566), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 30, 31, April 1, 2, 7, 8, 9, 10, 13, 2015.

The following critical incident intakes were inspected concurrently with this RQI: T-1188-14, T-1190-14, T-1971-15.

During the course of the inspection, the inspector(s) spoke with administrator, acting director of care, social service coordinator, food service manager, manager of clinical informatics, environmental services manager (ESM), maintenance technician, registered staff, personal support workers (PSWs), dietary aides, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. (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).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A record review of resident #005's current care plan revealed that the resident requires assistance of two staff for toileting.

During interview, an identified PSW reported that the resident required extensive assistance of one staff for toileting, and that was how he/she had toileted the resident during the day shift on an identified date. The identified PSW confirmed that he/she referred to the activities of daily living section of the resident dash tab on Point Click Care (PCC) for the resident's care information and demonstrated to the inspector where this was outlined.

An interview with an identified member of the registered nursing staff revealed that the resident's care plan had been revised from one person to two person assistance for toileting in February 2015, in order to reflect the resident's current needs.

An interview with the manager of clinical informatics confirmed that the conflicting information between the care plan and the resident dash tab on PCC could be confusing to direct care staff and provides unclear directions. [s. 6. (1) (c)]

2. The licensee has 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 with and complement each other.

Resident #009 was observed to have an abrasion or lesion, approximately 2 cm round, on March 31, 2015. On April 8, and April 10, 2015, this lesion was still present, and appeared to be scabbed.
During interview on April 10, 2015, registered staff was unaware of the presence of the scab, and the resident's PSW confirmed that he/she had noted the scab earlier this week, but forgot to inform registered staff as per the home's protocol.

Record review and staff interview confirm that no documentation of the abrasion or scab is present in the resident's record.
Interview with the home's acting DOC confirmed that as per the home's protocol, the resident's wound should have been reported to the registered staff by the PSW, and then further assessed and documented by the registered staff. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Staff interviews confirm that an identified registered staff member was not aware of the contents of resident #001's plan of care regarding side rails. The identified staff member was unaware that the resident's plan of care had been revised in December 2014 to include the use of two side rails while in bed. During interview, the identified staff member reported that the resident's plan of care called for only one side rail to be used for the resident while in bed. After review of the current care plan, the identified staff member confirmed that the care plan had been revised in December 2014, to indicate that the resident requires the use of two side rails up while in bed. [s. 6. (8)]

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:
-the plan of care sets out clear directions to staff and others who provide direct care to the resident,
-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 with and complement each other, and
-staff and others who provide direct care to a resident are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are kept closed and locked.

Observations on March 30, 2015, indicated that the door to the fifth floor south stairwell was unlocked, but equipped with a door access control system and an audible door alarm. Staff interviews revealed that the door is kept unlocked but equipped with an alarm, and can be accessed by residents on the fifth floor.

The home's environmental services manager (ESM) confirmed that all doors to stairwells should be kept locked and are connected to a control system which will sound an alarm when the doors are opened. The ESM confirmed that he/she was unaware that the mag lock system on the door was not functioning properly at this time. An interview with the Administrator confirmed that all stairwell doors should be equipped with a lock, and that the unlocked south stairwell door could pose a safety risk to residents.

On March 31, 2015, the ESM confirmed that a contractor had fixed an electrical issue and the door was now locked. Later on the same date, the inspector confirmed that the fifth floor south stairwell door was locked and functioning properly. [s. 9. (1)]

2. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

On March 30 and 31, 2015, the door to the telephone room on the home's main floor was found to be unlocked. This room contained multiple phone wires and connections. No staff was in the area on either occasion.

During interview, the home's ESM confirmed that the room should not be accessible to residents, and the door should have been locked. [s. 9. (1) 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 that all doors leading to stairways are kept closed and locked, and all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and its furnishings are maintained in a safe condition and in a good state of repair. On March 30, 2015, the following maintenance issues were observed:

Second floor:
- Wall damage in corridor to east wall outside Resident #007's room at waist level.
- Southwest dining room – unpainted patchwork (multiple areas) along north wall.
- Southeast dining room - chipped paint (floor level) on the east wall, unpainted patchwork in three areas on the west and south walls.
-Tub room – broken tile on the south wall and behind the door knob.
- Resident #007's room – scraped and gouged walls in the bedroom and the washroom. Three anchor holes in the wall above the sink.

Third floor:
- Southwest dining room – unpainted patchwork and wall damage; gouged wall north east corner
- Southeast dining room - unpainted patchwork on east/west walls.

Fourth floor:
- Resident #001's room - wall damage and tiles missing in the bathroom.
- Resident #008's room - paint in the washroom was peeling and cracking.

Fifth floor:
- Loose handrail on the west wall of the south corridor.

On April 9, 2015, maintenance personnel toured the areas previously identified and observed each of the maintenance issues as identified. The maintenance personnel stated that the fifth floor hand rail would be repaired immediately as it was a safety risk. The maintenance personnel confirmed that the home required the above identified repairs in order for the home to be maintained in a good state of repair, would prioritize and complete the identified repairs.

On April 10, 2015 the fifth floor hand rail was observed by the inspector to be secure. [s. 15. (2) (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 that the home and its furnishings are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.

Staff interviews and record review confirmed that on an identified date, an identified staff member did not use safe transferring techniques when transferring resident #011 off the toilet. The staff member attempted to transfer the resident using a mechanical standing lift with no other assistance. The resident slid from the lift to the floor, and sustained a fracture.

During interview, the identified staff member stated that he/she was aware that the resident's plan of care stated that the resident was to be transferred with a standing lift and two persons assist. The staff member stated that he/she was also aware that according to the home's lifts policy, two people are required to assist during a transfer using a mechanical lift. [s. 36.]

2. Staff interview and record review confirmed that on an identified date, an identified staff member did not use safe transferring techniques when transferring resident #016 from bed to wheelchair. The identified staff member attempted to transfer the resident using a mechanical standing lift with no other assistance. The resident slid from the sling and hit his/her head on the standing lift, causing a bruise and swelling.

Staff interview and record review confirmed that the resident's plan of care stated that the resident was to be transferred using a hoyer lift with two person assist.

During interview, the staff member involved confirmed that he/she was aware that the resident's plan of care stated that the resident was to be transferred with a hoyer mechanical lift with two persons assist. The staff member stated that he/she was also aware that the home's lifts policy dictated that two staff members must assist whenever a mechanical lift is used.

The home's acting DOC confirmed that two staff members should have been present during the entire lift process in both of these incidents. [s. 36.]

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 use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Staff interviews and record review confirmed that when resident #009 experienced altered skin integrity on an identified body part, the resident did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The inspector observed a red abrasion, approximately 2 cm round, on resident #009's body on March 31, 2015. On April 8 and April 10, 2015, the inspector again observed the abrasion, which appeared to be a scab. Record review revealed no assessment or documentation of the skin abrasion.

Interview with the identified registered staff on the morning of April 10, 2015, indicated that the registered staff member was not aware of the skin abrasion, and that it had not been documented or assessed.

Interview with an identified PSW confirmed that he/she observed the reddened, scabbed area earlier in the week, but did not document it, and forgot to report it to the registered staff on the unit. The identified PSW confirmed that he/she did not document the reddened, scabbed skin and should have reported it to the registered staff.

During interview, the home’s acting DOC confirmed that as per the home's policy, the resident's wound should have been assessed by a registered staff member using the home's electronic wound assessment instrument. [s. 50. (2) (b) (i)]

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 the resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's height annually.

A review of the clinical health records for residents #009 and #010 revealed, and an interview with an identified member of the registered nursing staff confirmed, that the most recent height measurement for both residents was from August 2013.

Interviews with the identified member of the registered nursing staff and the acting DOC confirmed that residents' heights should be taken annually and recorded on the electronic health record under the "weights/vitals" tab. [s. 68. (2) (e) (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 there is a weight monitoring system to measure and record each resident's height annually, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified date, inspectors observed a sign on the door of the resident #013's shared room which indicated that both "droplet plus contact" precautions are to be taken within the room. The sign stated that a long sleeved gown is required if there is to be contact with the resident or items in the room. The sign also stated that goggles and a procedure/surgical mask are required if within 2 metres of the resident.

On the morning of the following day, an identified PSW was observed providing care to resident #013. The PSW was wearing gloves and a mask, but no long sleeved gown or goggles while providing care to resident #013. An equipment caddy containing long sleeved gowns and masks was present outside the resident's room.

An interview with the identified PSW confirmed that he/she did not wear a gown or goggles when repositioning resident #013 in bed, even though the PSW was aware that the resident was on precautions for a respiratory illness. Interviews with identified PSWs and registered staff revealed further that goggles are not readily available on the units. A review of the home's infection prevention and control (IPAC) policy on Additional Precautions (IFC F-05, revised July 10, 2013) does not specify the need for protective eye wear when droplet precautions are in place.

An interview with an identified registered nurse confirmed that if resident #013 was repositioned by a PSW using only gloves and a mask, then the droplet precautions protocol was not being followed. The IPAC lead confirmed that staff are instructed to follow the directions on the posted signage on resident room doors, and encouraged to wear all personal protective equipment as posted. [s. 229. (4)]

2. The licensee has failed to ensure that a hand hygiene program is in place in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

Observations by the inspector throughout the inspection period revealed that resident rooms do not have hand hygiene agents accessible within the room. Further observations revealed that hand sanitizer units are present in the hallways on each floor, however each resident room does not have a hand sanitizer unit directly outside the room. There were fewer hand sanitizer units noted in the hallways on the second and third floors, as compared to the fourth and fifth floors.

Interviews with identified PSWs and registered staff revealed that the PSWs take a hand sanitizer pump around on their care carts when they provide morning care, but they do

not take the hand sanitizer or care carts around with them when personal care is provided throughout the rest of the day. Therefore there are periods throughout the day when hand sanitizer agents are not accessible within the room.

An interview with the IPAC lead confirmed that the home does not have point of care hand hygiene agents, they are aware that they are not meeting the best practices guidelines for hand hygiene, and are reportedly in the process of making changes to this program. [s. 229. (9)]

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 participate in the implementation of the infection prevention and control program, and that a hand hygiene program is in place in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

During the home tour on an identified date, resident #023 was observed to be seated in a wheelchair in the hallway of an identified floor. The resident was wearing only a hospital gown and an incontinence brief at the time. The brief was noted to be unfastened at the sides, and the hospital gown was positioned such that the resident's left side was fully exposed. The only staff member present at the time was a housekeeping aide.

The inspector immediately got the attention of an identified PSW who reported that resident #023 was in line for the spa which was why the resident was not dressed, and that the resident could be agitated. The PSW took the resident to his/her room, put an over coat on the resident and secured the top button only, then returned the resident to the hallway. The identified PSW confirmed that the resident should not be naked in the hallway, and that being exposed was a lack of dignity and respect.

Approximately five minutes later when the inspector passed the resident in the hallway the resident’s gown was again raised, exposing the resident's lower body.

An interview with the acting DOC confirmed that it is the home's expectation that residents are properly covered even while waiting for the spa, and that in this case the resident's right to be treated in a dignified manner was not respected and promoted. [s. 3. (1) 1.]

Issued on this 21st day of April, 2015

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

Original report signed by the inspector.