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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 21, 2016	2016_276537_0016	001537-14	Complaint

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

NANCY SINCLAIR (537), HELENE DESABRAIS (615), NATALIE MORONEY (610)

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): April 4, 5,6,7,8,11,12,13, 2016

The following Complaint inspections were completed concurrently with this inspection:

Log #001537-14/IL-33367-TO regarding dining, housekeeping, reporting and duty to protect.
Log #030681-15/IL-32436-TO regarding training requirements of staff, housekeeping, maintenance and menu planning.
Log #003047-14/IL-34019-TO regarding continence care.
Log #006022-14/IL-35108-TO continence care and sufficient staffing.
Log #007522-14/OCMS regarding skin and wound care, nutrition, bathing and supplies.
Log #009130-14/IL-36121-TO regarding dining and plan of care.
Log #030687-15/No IL regarding the use of restraints.
Log #000317-15/IL-36159-TO;IL-38503-TO;IL-38550-TO;IL-39416-TO regarding personal care issues.
Log #030665-15/IL-32060-TO regarding medical services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Program Manager, Social Services Coordinator, Environmental Services Manager,four Food Services Manager, Nursing Manager, Nursing Administration, four Registered Nurses(RN), seven Registered Practical Nurses (RPN), 15 Personal Support Workers(PSW), one Housekeeping Aide, four Dietary Aides, one Activation Aide, one Maintenance worker, and Residents.

The inspector(s) also conducted a tour of resident areas and common areas, observed residents and care provided to them, meal service, reviewed health care records and plans of care for identified residents, policies and procedures of the home, education and training records, general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Food Quality
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **5 WN(s)**
- **5 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care provided clear direction to staff and others who provided direct care to the resident.

Record review for an identified resident indicated an assessment for the use of side rails which differed from the direction in the care plan.

Interview with a Personal Support Worker confirmed that the resident used side rails per the information of the assessment. A Registered Nurse confirmed that the care plan did not reflect the use of side rails as per the assessed need.

The Director of Care confirmed it is the home's expectation that the written plan of care provided clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or the care in the plan was no longer necessary.

Review of the plan of care for an identified resident directed staff regarding specific interventions to be followed during meal service.

Observation of the resident at meal time revealed that the interventions were not being implemented for the resident.

An interview with a Personal Support Worker and Registered Nurse(RN) revealed that the specific interventions in the plan of care were not the care needs currently required by the resident and that alternate interventions were being implemented.

Interview with the Director of Care, confirmed that the resident's care needs had changed and that the care set out in the plan was no longer necessary. The DOC confirmed it was the home's expectation to review the care plan so it reflected the residents' needs. [s. 6. (10) (b)]

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 written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the plan of care is reviewed and revised when the resident's care needs changed or the care in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The homes policy titled "Skin Care and Wound Management Program" indicated the following:

"The head to toe assessment would be completed as follows:
• Upon any return form the hospital".
The head to toe assessment includes the following key areas:
•Skin (check for unusual marking or lesions to the skin surface. Note any bruising, reddened areas, abnormal lesions, jaundice, cyanosis, open areas, skin moisture or pruritus……)

•Face
•Mouth
•Bony Prominences
•Feet"

Review of the clinical record for an identified resident revealed per Point Click Care (PCC) progress notes that the resident was readmitted to the home with skin and wound alterations.

Further review of the progress notes on re-admission showed that the head to toe documentation did not identify the skin and wound alterations as identified in the PCC notes.

The Director of Care (DOC) confirmed that staff should have completed a head to toe assessment when the resident returned from the hospital and identified the skin and wound alterations as per the policy.

B) The homes policy titled "Admission, Transfers, and Discharges" indicated the following:

“The following assessment needs to be completed within seven (7) days of admission and summarized in the progress notes”.
•Nutritional Assessment
The assessment must include the following components not covered in the RAI MDS assessment on admission.
•The Registered Dietitian must complete a nutritional assessment on admission."

A review of PCC census record showed that the nutritional assessment for an identified resident was not completed within 7 days of admission.

The DOC confirmed that the resident should have had a nutrition assessment completed on admission as per the homes policy.

C) The homes policy titled "Meal Service Temperature Checks of Foods" indicated the following:

•To assure that food is served at acceptable temperatures.
•Staff must be aware of the danger Zone, 41 t0 140 Fahrenheit. Bacteria grow rapidly

within this temperature range. Prepared food should not be stored, held, or served in this temperature range."

Meal service policy for temperature checks of food indicated:
• "The Temperature of every food item in the steam table will be recorded on the food temperature form and initialled"

A review of the food temperature log book for lunch served on the second floor dining room showed the temperature logs were not documented before the meal was served.

The Dietary Manager confirmed that temperatures should have been checked and documentation should have been completed before serving the lunch meal as per the home's policy.

D) The home's policy titled "Bed Rails E-05" last reviewed March 10, 2016 indicated the following:
"All residents will be assessed at the time of admission to determine if bed rails(s) are required.
The need for bed rails(s) will be reassessed with any change in the resident's status or at least quarterly to reduce the risk of entrapment.
Admission assessment relating to bed rail(s) is coded in RAI MDS and documented in the care plan and admission template in the electronic progress notes.
Care plan reflects need and reason for bed rail(s)."

Interview with the Director of Care revealed that the assessment completed quarterly is documented in a structured progress note in Point Click Care called Sleep/Rest Patterns and is also recorded in Minimum Data Set(MDS) quarterly.

Review of the clinical record for an identified resident revealed an MDS assessment that indicated the use of side rails daily. The clinical record also had a Sleep/Rest Pattern note in Point Click Care(PCC) which indicated the use of side rails. The care plan was reviewed and did not indicate the use of side rails as per the MDS or the PCC note.

A Registered Nurse and a Registered Practical Nurse verified that the side rail use for this resident was not indicated in the care plan.

The Director of Care confirmed that the care plan for the resident did not have the use of bed rails included as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which prevented adulteration, contamination and food borne-illness.

Observation of the dining room on the second floor showed that there was a meal service tray on top of the steam table. The steam table was warm to touch and the plastic tray had a cream substance in a mug and tangerines in a bowl. Both items were left uncovered. There was salad in a bowl, covered by a lid, that was warm to touch.

Further observations of the fourth floor dining area revealed a tray on the steam table that had a facecloth, apron, empty yogurt container, and a meal that had been partially consumed.

A Registered Practical Nurse confirmed that the tray service was provided to a resident for lunch and should not have been left on the steam table. Two more trays from resident's room were placed on the sink area in the servery during this interview.

The homes policy titled "Meal Service and tray service" indicated the following:

"The Dietary Aid will provide the nursing staff with a covered tray upon request. The Personal support worker will remove the tray from the resident's room and return to the dietary department upon completion of the dining experience".

The homes policy titled "Meal Service Temperature Checks of Foods" indicated the following:
"•To assure that food is served at acceptable temperatures.
•Staff must be aware of the danger Zone, 41 t0 140 Fahrenheit. Bacteria grow rapidly within this temperature range. Prepared food should not be stored, held, or served in this temperature range.
•Foods must be covered until the meal services begins"

The Nurse Manager confirmed that the tray left on the second floor steam table was for a resident that was at a clinical appointment and that the tray was from the lunch time service which occurred two hours and 15 minutes prior to the observation.

The Director Of Care and the Dietary Manager confirmed that residents that were to be provided tray services should have had trays brought up from the kitchen then delivered to the resident when the resident returned and not left in the servery.

The Dietary Manager confirmed that it was the home's expectation that once a resident had completed a meal that the tray would be placed on the dining carts and that food and fluids were prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness. [s. 72. (3) (b)]

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 food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

A dining room observation showed that an identified resident was served a meal with no staff assistance available.

A review of the resident plan of care showed that the resident required total assistance with feeding by one staff member.

The homes policy titled "Meal Service Dining Room" indicated:
"Do not serve a resident that requires assistance until someone is available to provide assistance as required by the resident".

A Personal Support Worker confirmed that the meal had been served to the resident before a staff member was available to assist the resident and that the resident required total assistance with feeding.

The Director Of Care confirmed that the resident required total assistance to eat and should not have been provided a meal without staff to provide assistance. [s. 73. (2) (b)]

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 residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #5: 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. Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart, that is secured and locked.

A medication cart was observed next to the elevators on the fourth floor. The medication cart was unattended, unlocked and not secured.

The homes Quality Improvement Program, "Safe Storage of Drugs" indicated: "Drugs are stored in an area or a medication cart: that is secure and locked".

The Nurse Manager confirmed that the cart was unlocked and was left unattended.

The DOC confirmed that all medication carts should be locked when left unattended. [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 or a medication cart, that is secured and locked, to be implemented voluntarily.

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.