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 soins de longue durée

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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
Jun 26, 2017	2017_641513_0008	008358-17	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

JUDITH HART (513), DEREGE GEDA (645), SARAH KENNEDY (605)

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): May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 23, and 24, 2017.

The following critical incident inspections were conducted concurrently with the RQI: 010156-16 (related to duty to protect); 027173-16 (related to responsive behaviours); 007778-17 (related to duty to protect and responsive behaviours); 034284-16 (related to duty to protect); 028858-16 (related to duty to protect); 000029 -17 (related to transferring technique and duty to protect); 000258-17 (reports re critical incidents and falls prevention/management); 002104-17 (related to duty to protect); 007488-17 (related to transferring technique and reporting to Director); and 009727-17 (related to duty to protect).

The following complaint inspections were conducted concurrently with the RQI: 008662-17 (related to medication, skin/wound, duty to protect, accommodation services-housekeeping); and 027427-16 (related to reporting and complaints, and infection prevention and control).

During the course of the inspection, the inspector(s) spoke with residents, families, Substitute Decision Makers (SDMs), Administrator, Director of Nursing (DON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Physiotherapist (PT), Social Service Coordinator (SSC), Environmental Services Manager (ESM), Housekeeper, Nurse Manager (NM), Residents' Council President and Residents’ Council Assistant.

During the course of the inspection the inspectors conducted a tour of the home; observed medication administration, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, staff training records, meeting minutes for Residents' Council and relevant policies/procedures

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 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 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:
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 non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and locked when they are not supervised by staff.

During the initial tour of the home on May 1, 2017, a storage room on a designated floor was found to be open. The storage room contained shampoo, shaving creams, mouth wash, virox and other cleaning supplies that were accessible to residents. Staff members were observed in close proximity and residents were walking by the door.

On May 5, 2017, at 1115 hours the same storage room was observed to be open. All the cleaning chemicals were accessible to residents and residents were observed walking in close proximity to the open storage room. A Personal Support Worker (PSW) was observed closing the door after 20 minutes of the door being left open.

On May 10, 2017, at approximately 1400 hours the same storage room on the fourth floor was open and accessible to residents, containing the same cleaning supplies. An interview with PSW #105 revealed the cleaning chemicals should not be accessible to residents and the door was to be locked at all times. PSW #105 attempted to close and lock the door, but the door lock was not in working order and did not lock.

On May 10, 2017, inspector #645 and PSW #105 contacted the in-charge Registered Nurse (RN) #104, who was of the broken door lock. RN #104 reiterated that the door should be locked at all times and chemicals should not be accessible to residents. RN #104 contacted maintenance right away and the door lock was repaired and door was closed.

An interview with Environmental Service Manager (ESM) confirmed that the storage door should always be closed and locked. The cleaning supplies should not be accessible to residents. [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 non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and locked when they are not supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

A Critical Incident Report (CIR) was submitted by the home on a specified date in 2016, related to an allegation of abuse. A review of the CIR revealed that on this date in 2016, resident #031 was observed in the elevator to be exhibiting an identified responsive behaviour toward resident #034.

Resident #031 had a history of an identified responsive behaviour toward staff and there was one previous incident where resident #031 attempted to exhibit the same identified behaviour toward a resident. Police were contacted.

A review of resident #031's chart revealed the resident had no cognitive impairment. Inspector #605 attempted to interview resident #031 but resident #031 did not recall the incident. A review of the home's investigation notes revealed at the time of the incident it was believed that resident #031 understood his/her actions and the consequence of these actions. Resident #031 was being followed by an outreach team and at the time of the incident recommendations were implemented.

A review of resident #034's chart revealed he/she had moderate cognitive impairment. Inspector #605 attempted to interview resident #034, but the resident could not recall the incident. An interview with the Director of Nursing (DON) revealed at the time of the incident resident #034 could not recall the incident.

An interview with PSW #130 revealed he/she found resident #031 exhibiting an identified responsive behaviour toward resident #034. Following the incident, resident #034 had no noted change in behavior. Since this incident occurred, there have been no further occurrences.

An interview with the DON confirmed resident #034 had been abused by resident #031. [s. 19. (1)]

2. a. A CIR was submitted by the home on a specified date in 2016, related to an allegation of abuse. A review of the CIR revealed on this date resident #032 exhibited an identified responsive behaviour toward resident #031 causing injury. The police were notified.

A review of resident #032's chart revealed he/she had moderate/severe cognitive impairment. Inspector #605 was not able to interview resident #032.

A review of resident #031's chart revealed he/she had an identified cognitive impairment. Inspector #605 was not able to interview resident #031.

An interview with PSW #135 revealed he/she observed resident #032 exhibit an identified responsive behaviour toward resident #031. A review of resident #031's progress notes revealed after the incident resident #032 sustained an identified injury. After the incident, resident #032 was assessed by an outside resource and interventions were implemented as recommended.

b. A second CIR involving resident #032 was submitted by the home on a specified date in 2017, related to an allegation of abuse. A review of the CIR revealed on another date in 2017, resident #032 exhibited a responsive behaviour toward resident #033 causing pain and further assessment for injury.The police were contacted and the Long-term Care (LTC) home emergency pager was notified. The resident was sent to hospital for assessment and no injury was noted.

A review of resident #033's progress notes revealed he/she had pain immediately after

the incident and continued to receive medications as previously prescribed. An interview with resident #033 revealed he/she continues to be scared of resident #032, but does not see him/her anymore.

A review of the resident #032’s chart revealed immediately after the second incident, resident #032 was sent to an outside resource for further assessment for an identified period of time. Resident #032 returned to The O’Neill Centre on a specified date. Upon admission to the home, new behaviour interventions were implemented and he/she received an identified intervention for an identified period of time.

An interview with the DON revealed resident #032 was abusive toward resident’s #031 and #033. [s. 19. (1)]

3. A CIR was submitted by the home on a specified date in 2017, related to an allegation of abuse. A review of the CIR revealed on the specified date in 2017, resident #038 entered into resident #035’s room where there was an identified interaction causing an identified injury to resident #038. Resident #038 was sent to hospital for assessment and received treatment. The police were contacted.

A review of resident #038’s chart revealed he/she had an identified diagnosis and identified responsive behaviours. At the time of the incident interventions to minimize the identified behaviours were in place. Record review confirmed resident #038 sustained an identified injury. Inspector #605 was unable to interview resident #038.

An interview with resident #035 revealed he/she exhibited an identified responsive behaviour toward resident #038 when resident #038 entered into his/her room. Resident #035 is cognitively well and understands the impact of the incident.

An interview with the DON revealed resident #035 was abusive toward resident #038. [s. 19. (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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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 and positioning devices or techniques when assisting residents #022.

A CIR was submitted by the home on a specified date in 2017, which revealed resident #022 sustained an alteration in skin integrity while the resident was assisted with mobility care by PSW #108 and #113.

A record review of the written plan of care indicated that resident #022 required two person assistance with mechanical lift transfer.

An interview with PSW #108 confirmed that he/she manually transferred resident #022 with PSW #113 on a specified date in 2017. He/she confirmed that the resident was transferred from the wheelchair to the bed by manually holding a specified body area. PSW #108 confirmed that it was an unsafe transfer as the care plan directs staff to use a mechanical lift for transfers.

An interview with PSW #113 confirmed that the resident was transferred manually and the mechanical lift was not used as the care plan directed. He/she confirmed that it was an improper transfer and resident #022 sustained an alteration in skin integrity. [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 and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A review of the Spills Action Centre (SAC) report, called into the Ministry of Health and Long-term Care (MOHLTC) on a specified date in 2017, revealed resident #038 entered into a designated area. PSW #142 asked resident #038 to leave this area and resident #038 exhibited a responsive behaviour. While resident #038 was exhibiting an identified responsive behaviour, resident #039 received an identified injury. Police and families were notified.

An interview with PSW #142 revealed at the time of the incident resident #039 was sitting in a mobility device outside of a designated area, waiting for care. While PSW #142 was moving resident #038 out this area, he/she exhibited an identified responsive behaviour toward PSW #142, but instead caused an identified interaction with resident #039. A review of resident #039's chart revealed he/she sustained an alteration in skin integrity.

A review of resident #038's chart revealed he/she is cognitively impaired. Inspector #605 was unable to interview resident #038. A review of an outside resource follow-up report revealed resident #038 was seen on a specified date in 2017, for identified responsive behaviours. Several recommendations were offered.

A review of resident #038's current written care plan revealed the care plan had not been updated to include the recommendation from the outside resource assessment in 2017. An interview with the DON revealed the expectation is not necessarily for the written care plan to be updated, but this information needs to be shared with staff and available as part of the resident's plan of care.

An interview with Nurse Manager (NM) #102 confirmed that resident #039 sustained an injury. An interview with the DON revealed the recommendation from a specified date in 2017, would not have applied to the situation that occurred between resident #039 and #038. The resident needed to be removed from the designated location as he/she could not be left unattended or unsupervised. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

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

Observations on May 5, 2017, were made during the noon medication administration to residents on the second floor by RPN #122.

The home's policy for hand hygiene (IFC H-15, revised May 31, 2016) was reviewed. The policy includes the four moments of hand hygiene, which are: 1. before initial resident/resident environment contact; 2. before aseptic procedures; 3. after body fluid exposure risk; and 4. after resident/resident environment risk.

Observations of the noon medication pass on a designated date in 2017, by RPN #122 revealed 10 medications were administered without hand hygiene being performed before and after initial resident contact.

An interview with RPN #122 confirmed that hand hygiene was not performed when administering the observed medications during the noon medication pass. An interview with the DON confirmed staff are to perform hand hygiene when administering medications as indicated by the four moments of hand hygiene. [s. 229. (4)]

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, to be implemented voluntarily.

WN #6: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On a designated date in 2017, observations were made during the noon medication administration to residents on a specified floor by RPN #122.

Observations during the medication administration revealed the medication pouches for all medications administered for residents #015, #016, and #017 were found in an open rubbish container on the medication cart, revealing each resident's name and medication.

Interviews with RPN #122 and #RPN #143 revealed the medication pouches were to be torn to separate the resident's name from the medication. The torn pouch would be placed in the rubbish bag on the medication cart and when the bag was full it would be placed in a general rubbish bin on the unit and/or placed in a large rubbish bin in the locked utility room on the unit. The large rubbish bin would be placed outside for general pick-up.

An interview with the DON confirmed that with this process resident personal health information was compromised. [s. 3. (1) 11. iv.]

WN #7: 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 put in place is complied with.

Observations on a designated date in 2017, were made for the noon medication administration to residents on a specified floor.

A review of Medication Administration Policy Index ID F-05, revised March 17, 2017, states, "all medications administered must be signed off electronically as given by the registered staff as soon as the medications have been given."

During the observation of the noon medication pass on the above date for resident #012, it was observed that the noon medication packet for this resident was missing three identified medications. These medications were not signed off in the Electronic Medication Administration Record (eMAR) as administered. RPN #122 questioned RPN #143, who was also administering medications during the noon medication pass and confirmed that RPN #143 had administered these medications to resident #012, because he/she was trying to assist RPN #122. An interview with RPN #143 confirmed that he/she had been called away by another resident after the medications had been administered and forgot to sign-off the eMAR.

An interview with the DON confirmed that the home's expectation is for medications to be signed off in the eMAR immediately following administration as per the home's policy. [s. 8. (1) (b)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.