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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 16, 2019	2019_671684_0017	013004-17, 025068-17, 006486-18, 007549-18, 008396-18, 009519-18, 009662-18, 011237-18, 017993-18, 019772-18, 023519-18, 027015-18, 027027-18, 032911-18, 000254-19	Critical Incident System

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

SHELLEY MURPHY (684), COREY GREEN (722), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 6-10, 2019.

The following intakes were inspected during this Critical Incident Inspection:

- Six logs, related to falls prevention;

- Two logs, related to change in resident condition;

- One log, related to lifts and transfers;

- Two logs, related to alleged resident to resident abuse;

- Two logs, related to responsive behaviours;

- One log, related to alleged staff to resident abuse; and,

- One log, related to controlled substances.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Former Director of Care (FDOC), Nurse Managers (RNs), Registered Practical Nurses (RPNs), Restorative Care, Behaviour Support Manager, Personal Support Workers (PSWs), Receptionist, residents and their families.

The Inspector(s) also conducted daily tours of the resident care areas, observed provision of care and services to residents, reviewed relevant licensee policies, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
1 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	Légende 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. 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 failed to ensure that staff used safe transferring techniques and positioning devices when assisting residents.

A critical incident (CI) report was submitted to the Director for an incident that occurred on a specified date in 2017; where, resident #001 was injured during a transfer, resulting in a change in condition. A review of the resident's health care records indicated that their health status was such that they required a mobility aid, and were assisted by on staff for their activities of daily living.

Progress notes for resident #001 were reviewed by Inspector #722. A progress note on specified date in 2017, indicated that resident #001 was involved in an incident when they had a change in position from a piece of equipment while staff were trying to provide care to them. A subsequent progress note indicated that the resident was to be further assessed based on verbal remarks from the resident, and the nursing staff identified an area of altered skin integrity. A progress note on a specified date in 2017, indicated that the resident was assessed and a change in condition was noted.

Inspector #722 reviewed the investigation notes for this incident, which included the following:

- Hand-written notes by RN #109, a nurse supervisor, for an interview with PSW #105 which indicated that PSW #105 had taken the resident to their room and provided care to the resident; while waiting for assistance from the another PSW the resident was involved in an incident.

- Hand-written notes for a meeting with PSW #105 written by RN #103 indicated that PSW #105 stated they had provided care to resident #001, and during this process an incident occurred. The notes also indicated that the Former Director of Care (FDOC) stated to PSW #105 that the care they had provided was to be completed by a specified number of staff.

- Typed notes by RN #103, for a interview with PSW #105, indicated that PSW #105 stated how they provided care to resident #001. The notes indicated that the PSW stated that the resident had a change in position while using a piece of equipment. PSW #105 stated that PSW #107 arrived at the room quickly after the incident, and immediately called for the charge nurse; two other PSWs entered the room, and after RPN #106 assessed the resident and provided approval for the PSW staff to move the resident into a proper position. The PSWs moved resident #001 and did not follow the specified intervention for resident #001.

- A hand-written statement by PSW #105 indicated that they had provided care to resident #001, and during this process an incident occurred, PSW #105 indicated in the letter that, after RPN #106 had seen the resident, the direct care staff moved the resident into a proper position. PSW #105 acknowledged in the statement how the specified care was to be provided to resident #001.

- A typed letter from the FDOC to PSW #105, indicated that resident #001 had a change in condition related to improper care being provided.

Inspector #722 reviewed the resident's care plan, which indicated a specific intervention and how it was to be utilized for resident #001.

The latest quarterly RAI-MDS assessment for resident #001 was reviewed by Inspector #722, and indicated specifics on how interventions were to be provided to resident #001.

Inspector #722 reviewed the licensee's policy "Transfers" (Index E-20), original date March 23, 2001, last revised May 3, 2019, which indicated the following under Procedure:
-Resident's ability to transfer will be assessed upon admission (Lift/Transfer & Bed Rail Assessment), quarterly with the RAI-MDS process and on change of status of resident. Transfer method must be reflected in the plan of care.
-Resident requiring the use of a mechanical lift and/or ceiling lift will be assisted by two staff at all times to promote both resident and staff safety.
-Position resident's arms according to sling being used (in or out).

During an interview with Inspector #722, PSW #105 confirmed the details from the investigation notes described above. PSW #105 acknowledged that they were aware of the specific intervention and how it was to be utilized for resident #001, but they did not

initially understand that this also applied to another part of the intervention. The PSW verified that they should have had assistance from another staff member.

During an interview with RN #103, the nurse manager involved in the investigation of this incident, they confirmed that resident #001 was not provided care according to the resident's plan of care, and according to the home's specified policy. RN #103 indicated that the expectation was that PSW #105 should have had assistance from another staff member, and that direct care staff should have followed the specified care plan intervention for resident #001. [s. 36.]

2. A CI report was submitted to the Director on a specified date in 2018, regarding an incident that caused an injury to a resident for which the resident required medical assessment and resulted in a significant change in the resident's health status. The CI report indicated that resident #013 had a change in condition, while PSW #120 was providing them care.

Inspector #627 reviewed the home's policy titled ""Resident Safety-Transfers", original date March 23, 2001, last revised May 3, 2019, which indicated that the transfer method must be reflected in the plan of care, check the transfer status of the resident as per plan of care and assess the residents current ability to bear weight while in bed or sitting up".

Inspector #627 reviewed resident #013's care plan in effect at the time of the incident, for a specific intervention. The care plan indicated that a specified number of staff members were required for the specified intervention.

Inspector #627 reviewed the home's investigation notes for the incident which contained a hand written note from PSW #120 describing the event. The note indicated that PSW #120 completed the intervention by themselves, and that they noted a changed in resident condition while providing the care.

Inspector #627 interviewed PSW #120. The PSW stated that they had provided care to resident #013 by conducting a specific intervention by themselves. PSW #120 demonstrated to the Inspector how they had completed the intervention, and stated that they noted a change in condition while providing care to resident #013. PSW #120 acknowledged that they were not sure what was in the resident's care plan in regards to this intervention as they had not checked the resident's care plan prior to providing the care.

Inspector #627 interviewed the DOC, who stated that the expectation would be that a specified number of PSWs would have completed the intervention for resident #013, for the safety of the resident, as well as the staff member, and that a specified number of staff members were to complete the intervention as indicated in their care plan. They further stated that at no time were staff to complete the intervention for a resident with a specified health status by themselves. [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 the staff ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CI report was submitted to the Director on a specified date in 2017, for an incident where resident #001 had a change in position from a piece of equipment while receiving care by PSW #105, which resulted in a change in condition.

Review of the health records by Inspector #722 indicated that resident #001 was dependent on staff for all activities of daily living.

The investigation notes for this incident were reviewed by Inspector #722. Hand-written notes by RN #109, a nurse supervisor, for an interview with PSW #105 indicated that PSW #105 had taken the resident to their room while using a piece of equipment, provided care to the resident, and while waiting for assistance from the another PSW the resident was involved in an incident. Notes from a telephone interview with PSW #105 showed RN #105 had asked if PSW #105 provided care to resident #001 without assistance of another PSW. PSW #105 stated, "That's what we normally do".

Resident #001's care plan was reviewed by Inspector #722, which indicated the following for resident #001 Extensive Assistance provided by a specified number of persons for physical assistance.

During an interview with Inspector #722, PSW #105 indicated that they had provided care to resident #001 on a specified date in 2017, returned the resident to their room, called for assistance from another PSW, and had performed resident care without assistance from another staff member. The PSW indicated that they were not aware that the plan of care indicated that they were to have another staff assist them. The PSW also confirmed the contents of the investigation notes by RN #103 and RN #109, as described above.

During an interview with Inspector #722, RN #103, who was involved in the investigation for this incident, confirmed that a specified number of staff were supposed to assist resident #001 with care, and that the resident did not receive care as specified in their plan of care.

2. The licensee failed to ensure that the provision of care, set out in the plan of care was documented.

A CI report was submitted to the Director on a specified date in 2018, in regards to an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health status. The CI report indicated that on a specified date in 2018, resident #011 was involved in an incident. At the time of the incident, the resident had no change in condition. A number of days later it was noted by a PSW that resident #011 was exhibiting different symptoms to indicated they may have had a change in condition. A few days later, the resident's condition had changed.

Resident #011 was further assessed medically and had a new diagnosis which indicated a change in condition.

Inspector #627 reviewed resident #011's progress notes which revealed a note written by RPN #106; "PSW reported to writer that the resident was was exhibiting different signs and symptoms during care. The assessment noted a change in condition. Inspector #627 reviewed the documentation for the following shift, and could not identify a follow up assessment for resident #011's change in condition.

Inspector #627 reviewed the home's policy titled "Assessment/Documentation", I.D:C-10-05, which indicated the following: "entries should include but not be limited to any observations about resident's condition".

Inspector #627 interviewed RPN #126 who indicated that they had been told during shift report that resident #011 had a change in condition. RPN #126 stated that they had assessed the resident had for a change in condition. They further stated that the home's policy was to document all assessments and that they had "missed that one".

Inspector #627 interviewed Nurse Manager #103 who stated that when a resident presented with a change in condition, they were to be assessed by the registered staff. The assessments, interventions and the effectiveness of the interventions were to be documented, and reported to the oncoming shift for follow up, verbally and from the PCC shift report. Nurse Manager #103 stated that they had found some gaps in the documenting on specified dates in 2018, as RPN #126 had not documented their follow up assessment in PCC of resident #011. Nurse Manager #103 indicated that RPN #126 had not followed the home's documentation policy. [s. 6. (9) 1.]

WN #3: 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 had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in a risk of harm to the resident.

A CI report was submitted to the Director on a specified date in 2018, related to an incident of resident to resident abuse which occurred a number of days prior to the CI submission.

Inspector #684 reviewed the progress notes for resident #010 which indicated the following: on a specified date when the resident's SDM was made aware of the incident.

Inspector #684 interviewed RPN #112 who stated they remembered the incident involving resident #009 and #010 which occurred on a specified date in 2018. RPN #112 told Inspector #684 that when they had an incident of resident to resident abuse they reported it to the nurse manager right away. When asked who reports it to the Ministry of Health (MOH) they stated management, nurse manager, DOC, any one of them.

Inspector #684 reviewed a discipline letter for RPN #112 which stated "This letter serves as a record of discipline related to failure to report an allegation of resident-to-resident

abuse to the Nurse Manager(s) which resulted in an investigation for alleged resident-to-resident abuse which was validated."

Inspector #684 reviewed the home's policy titled Critical Incidents, E-45, which was in place at the time of the incident, which stated
"1. All critical incidents, which pose a risk to residents, are to be reported to the Manager/Director of Care immediately. Incidents that required involvement from outside agencies must be documented in the electronic critical incident system. Such incidents shall include, but not be limited to:
a) alleged or actual abuse/assault involving resident
2. The Director of Care or designate will be responsible for communicating all critical incidents to Ministry of Health Long Term Care. Staff who report alleged abuse cases will also sign off on the CIS to acknowledge reporting had occurred.
3. LTCHA, Subsection24 (1) - Reporting Certain Matters to the Director: A person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which was based to the Director:
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."

Inspector #684 interviewed the DOC and asked when you have an incident of resident to resident abuse what is the time frame for reporting to the MOH. The DOC responded "immediately". The DOC stated they would have nursing staff call the MOH after hours line. The CI report was reviewed with the DOC looking at the specified date the incident occurred. The incident was not reported until a day later. The DOC verified that it should have been reported immediately, and that it was reported late. [s. 24. (1)]

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 22nd day of May, 2019

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

Original report signed by the inspector.