Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_642698_0012	007265-20	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

ORALDEEN BROWN (698)

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): June 29, 30, and July 2, 2020 as an off-site inspection.

The following intakes were inspected:
-log #007265-20 related to multiple care areas.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and family member.

During the course of this inspection, the inspector reviewed Resident Assessment Instrument-Minimum Data Set (RAI-MDS),
assessments, plan of care, progress notes, Resident Assessment Protocols (RAPS) and Medication Assessment Records (MARS).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 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 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).

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 Critical Incident System (CIS) #2631-000016-20 was submitted to the Ministry of Long-Term Care (MLTC) on April17, 2020, relating to alleged staff to resident physical abuse towards resident #001.

A record review of the home's CIS, inquiry notes and staff interviews was done by Inspector 698 and no injuries were identified.
There was no non-compliance identified as a result of the inspection related to Prevention of Abuse and Neglect. Non-compliance was identified under plan of care for not providing care set out in the resident's care plan.

Review of resident #001's care plan dated February 26, 2020, revealed that they require extensive assistance two person physical assistance during bed mobility and incontinent changes.

Record review of the home's investigation notes revealed that PSW #100 did not follow resident #001's plan of care which requires two-person assistance. Personal Support Worker (PSW) #100 was given a verbal warning letter with education on Code of Conduct of Business Ethics, The Abuse and Neglect Policy, Resident Bill of Rights, and Therapeutic communication strategies.

During an interview with PSW #100, they indicated that resident #001 required total care with two-person assistance for incontinent care changes. They stated that on April 16, 2020 they provided care to resident #001 at 1630 hours (hrs), 2000hrs and 2230 hrs. They continued to say that after resident #001's second change at 2000 hrs, they went on to provide care to other residents when resident #001 began yelling from their room and ringing the call bell. PSW #100 continued to say that when they entered the room, resident #001 had the television remote in their hand and was pointing to their brief, motioning to have it changed. PSW #100 was unable to understand resident #001 due to language barrier. PSW #100 indicated that they were aware of the resident's plan of care requiring two staff but went ahead and provided care by themselves so that resident #001 would stop yelling and calling out. PSW #100 continued to say that as a result, they were suspended for four days with educational training as well. They were also no longer permitted to provide care for resident #001.

During an interview with DOC #102, they indicated that PSW #100 provided care to the resident by themself and did not follow the resident's plan of care which requires two-person care as set out in the care plan. DOC #102 confirmed that PSW #100 was

disciplined and provided retraining. [s. 6. (7)]

Issued on this 16th day of July, 2020

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

Original report signed by the inspector.