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

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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
Jul 26, 2021	2021_769646_0012	004016-20, 016891-20, 001851-21, 006470-21	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

IVY LAM (646)

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): July 6, 7, 8, 9, and 13, 14, 15 and 16, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log # 004016-20, Critical Incident System (CIS) #2631-000003-20 related to alleged neglect,
Log # 016891-20, CIS #2631-000023-20 related to alleged financial abuse,
Log #001851-21, CIS # 2631-000003-21 related to improper care of a resident, and
Log #006470-21, CIS #2631-000006-21 related to a medication error.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPNs), Infection Prevention and Control (IPAC) Manager, Falls Lead, Personal Support Workers (PSW), Housekeepers and Residents.

During the course of the inspection, the inspector conducted a tour of the home, observed staff to resident interactions, and the provision of care, reviewed residents' health records and home records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

4 WN(s)
2 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 has failed to ensure that staff used safe positioning techniques when assisting one resident.

A resident required two-person extensive assistance for bed mobility. A Personal Support Worker (PSW) began to provide care for the resident on their own without waiting for their partner for assistance. The PSW assisted the resident with bed mobility, when the resident fell to the floor and sustained an injury. An x-ray completed afterwards identified a second injury.

The PSW indicated they were aware that the resident required two staff members for care, but their partner was not yet available. The PSW stated they assisted the resident with bed mobility alone when the resident fell. They further stated that if there was another PSW assisting, the resident may not have fallen.

The other PSW stated they were the second person to provide assistance and both PSWs were to provide care for the resident, but the first PSW began care without waiting for them to come and assist.

The RN indicated they were available at the time and the PSW should have called the RN if they needed a second person to for care, but the PSW did not do so.

The Director of Care (DOC) indicated the PSW did not safely position the resident.

There was a risk of injury to the resident when the PSW did not safely position the resident for bed mobility. The resident sustained injuries as a result of this incident.

[Sources: Critical Incident System (CIS) report, the resident's care plans, progress notes, home's investigation records, risk management notes, education records, x-ray report; observations of the resident; interviews with PSWs, RN, and the DOC] [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 positioning techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the medication administered to a resident was in accordance with the directions for use specified by the prescriber.

A resident was prescribed a long-acting medication. The resident was also prescribed rapid-acting medication when indicated by a point of care diagnostic.

An RN checked the resident's point of care diagnostic, and based on the Electronic Medication Administration Record (eMAR) order, the rapid-acting medication was not needed for the resident. However, the RN administered the rapid-acting medication instead of the long-acting medication. After discussion with another RN, the first RN realized they administered the wrong medication to the resident. The resident was sent to the hospital where they were treated and returned to the home. No ill-effects were identified for the resident as a result of the incident.

The first RN indicated they did not see the long- acting medication for the resident as it was closer to the front of the resident’s medication slot. The RN took the rapid-acting medication instead, which had the same manufacturer name, and administered it to the resident. The RN acknowledged they should not have administered the rapid-acting medication to the resident

The DOC indicated first RN had misread the label but should have checked the medication more carefully or asked the regular RN in the home area to verify the medication, if they had not worked recently with the resident. The DOC indicated that staff did not administer the correct medication to the resident in accordance with the directions for use specified by the prescriber at the time of the incident.

There was a risk of adverse health effects when the resident was not administered the correct type and dosage of medication as specified by the prescriber.

[Sources: CIS report , resident’s care plan, Electronic Medication Administration Record (eMAR), Home’s Medication Administration Policy, Medication error tracking document, Medication trends and analysis, Home’s investigation notes, Physician’s digiorder, progress notes, hospital records; observations of the resident and medication administration; interviews with RNs, and DOC.] [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (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 a resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The resident’s current care plan indicated there were interventions in place for the resident’s safety. Observations of the resident and their room showed staff used different interventions than what was in the care plan.

Two PSWs and the RN indicated the resident’s safety needs had changed and different interventions were put in place. The Falls Lead/Nurse Manager (NM) indicated the resident’s needs had changed, but the care plan was not updated when the intervention changed.

The DOC indicated the care plan should have been updated when the resident’s care needs and interventions changed, but the care plan was not revised.

There was a risk that the resident would not be provided their required interventions when their care plan was not updated when their care needs changed.

[Sources: Resident’s care plans; observations of the resident and the resident’s room; interviews with PSWs, RN, Falls lead/Nurse Manager, and the DOC] [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperatures required to be measured were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the home's Air Temperature Tracking Tool showed measurements were documented at 1300 and 1800 hours until June 14, 2021. Between June 15 to July 6, 2021, temperatures were measured at 1300, 1800 and 0100 hours. The morning air temperatures were not measured and documented.

The Nurse Manger (NM) indicated that the nurse managers were responsible for measuring the air temperature in the home, and measurements were taken three times daily at 1300, 1800 and 0100 hours. The NM acknowledged that the air temperature was not measured and documented in the morning.

The DOC and Executive Director (ED) indicated that the home did not measure and document the air temperature in the morning, as required.

[Sources: Review of the home’s Air Temperature Tracking Tools, the Home's Hot Weather-Related Illness policy; observations of thermohygrometers in the home, walkabout with nurse manager to observe air temperature measurement and recording; interviews with NM, DOC, and the ED]. [s. 21. (3)]

Issued on this 30th day of July, 2021

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

Original report signed by the inspector.