Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, 24, Sep 6, 7, 10, 2012	2012_108110_0014	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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Staff Educator, Registered Staff, Personal Support Workers, family and residents.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home policies and staff education records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee did not take appropriate action in January 2012 when the homes was conducting their own internal Abaqis interviewing process an identified resident stated" yes" when asked "Have you ever been treated roughly by staff".

On August 23rd, 2012 during resident interviews conducted by the Ministry of Health (MOH) inspector the same identified resident expressed "yes" when asked "have you ever been treated roughly by staff". Identified resident stated "one of the nurses, is very rough and not very careful. I've cried out actually. I have asked this staff to be gentler but he/she doesn't listen." A staff name was provided.
On August 23rd, 2012 the named staff member was interviewed by MOH inspector and his/her response revealed that "sometimes residents will tell me that it's too rough. But what is too rough I don't think it's rough."
The Director of Care (DOC) stated on August 24th, 2012 that the identified resident did not disclose staff names during the interview of January 25th, 2012. The DOC stated her follow up was speaking to staff on the units about general "customer service" towards residents. The DOC stated that no formal follow-up related to this incident was conducted.

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 appropriate action taken in response to every alleged, suspected or witnessed incident of abuse., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to provide annual training in Abuse recognition and prevention to direct care staff pursuant to section O.Reg 79/10 s.221(2).
Educational records for 2011 confirmed that 73.3% of staff were provided training in Abuse recognition and prevention.
An interview with the Director of Nursing confirmed that all direct care staff were not provided training in 2011.[s.76.(7)1]
2. The Licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.
Staff interviews revealed that staff training regarding mandatory reporting under section
24 of the Act involves instructing staff to inform their supervisor or Director of Care of any concerns they might have about abuse of
residents, and then the Administrator, or Director of Nursing have an obligation to report it to the Ministry of Health.
The "code of conduct and Business Ethics" educational material used within the home states "on becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Administrator, or if not available, the Director of Nursing/ or Delegate."
An interview with the Administrator on September 7th, 2012 revealed that the home has not clearly advised staff on their duty to report any knowledge of abuse to the Director.
Mandatory Reporting under section
24 of the Act states that ANY PERSON who has knowledge of abuse of a resident has a duty to report it to the Director under the Act, and that it is an offence for staff not to report it. [s.76.(2)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 receive training in the area of mandatory reporting under section 24 of the Act of abuse or neglect resulting in harm or potential harm to a resident and that all staff who provide direct care to residents receive annual training in abuse recognition and prevention., to be implemented voluntarily.

Issued on this 11th day of September, 2012

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