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 sions 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
Apr 21, 2016	2016_276537_0017	004416-14	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

NANCY SINCLAIR (537), ANN POGUE (636), HELENE DESABRAIS (615), NATALIE MORONEY (610)

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): April 4, 5, 6, 7, 8, 11, 12, 13, 2016

The following Critical Incident Inspections were conducted concurrently during this inspection:
Log #004416-14/CIS 2631-000032-14;2631-000011-14 regarding alleged resident to resident abuse.

Log #003791-15/CIS 2631-000013-15;2631-000037-15 regarding alleged resident to resident abuse.
Log #008345-14/CIS 2631-000039-14 regarding resident personal care concerns.
Log #006236-15/CIS 2631-000014-15 regarding resident personal care concerns.
Log #008678-14/CIS 2631-000040-14 regarding alleged staff to resident abuse.
Log #030657-15/CIS 2631-000012-14 alleged staff to resident abuse.
Log #020347-15/CIS 2631-000028-15 alleged staff to resident abuse.
Log #012800-15/CIS 2631-000018-15 alleged staff to resident abuse.
Log #012691-15/CIS 2631-000017-15 alleged staff to resident abuse.
Log #009052-15/CIS 2631-000032-13 alleged staff to resident abuse.
Log #002377-15/CIS 2631-000029-14 alleged staff to resident abuse.
Log #001955-14/CIS 2631-000021-14 regarding injury resulting in transfer to hospital.
Log #030257-15/CIS 2631-000032-15 regarding transferring techniques.
Log #001041-15/CIS 2631-000001-15;2631-000007-15;2631-000020-15 regarding the management of responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Program Manager, Social Services Coordinator, Environmental Services Manager, Food Services Manager, Nursing Manager, Nursing Administration, four Registered Nurses(RN), seven Registered Practical Nurses (RPN), 15 Personal Support Workers(PSW), one Housekeeping Aide, four Dietary Aides, one Activation Aide, one Maintenance worker, and Residents.

The inspector(s) also conducted a tour of resident areas and common areas, observed residents and care provided to them, meal service, reviewed health care records and plans of care for identified residents, policies and procedures of the home, education and training records, program evaluations, general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Clinical record review for an identified resident revealed incidents of impaired skin integrity of unknown causes, documented in the home's risk management and progress notes.

An interview with a Personal Support Worker(PSW), a Registered Practical Nurse(RPN) and a Registered Nurse(RN) confirmed that the resident was prone to incidents of altered skin integrity and interventions had been implemented as a result.

Review of the resident's plan of care revealed no documented evidence of the resident's skin integrity impairment, goals or interventions.

An interview with an RPN, an RN and the Director of Care confirmed there were no documented goals and interventions for the resident's skin integrity impairment.

The Director of Care confirmed that the resident had altered skin integrity issues identified and that there were no documented goals and interventions in the current plan of care. [s. 6. (2)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed.

Clinical record review for an identified resident revealed recommendations for interventions to address the identified responsive behaviours for the resident.

Review of the resident's plan of care revealed no documentation of the resident's care needs regarding responsive behaviours.

An interview with a Personal Support Worker and two Registered Nurses confirmed that the resident had responsive behaviours, and that the interventions that had been recommended were being implemented.

An interview with the Social Service Coordinator and the Director of Care(DOC) confirmed that the resident had responsive behaviours and that the recommendations were put in place and that the resident's plan of care did not reflect the residents care needs.

The DOC confirmed that it was the home's expectation that the resident's plan of care be reviewed and revised when the resident care needs change. [s. 6. (10) (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 that the plan of care is based on an assessment of the resident and the resident's needs and preferences, and that the plan of care was reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #2: 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 instituted or otherwise put in place was complied with.

The Home's policy titled "Safe Operating Procedure (SOP) Resident Transfer- Using Lifts Safely - Q-05-40", last revised August 8, 2016, stated "Prior to using the lift, staff is expected to check the transfer status of the resident as per plan of care and assess the resident's current ability to bear weight while in bed or sitting up. As a safety precaution, get a second staff member to assist with the lift. In the event of injury, staff member is to seek immediate medical attention and notify the supervisor".

The Home's policy titled "Transfers - E-20" last revised March 10, 2016 stated "Resident will be assessed/reassessed for ability to transfer by Registered Staff. A mechanical lift will be used when deemed appropriate to provide lifts/transfers that are safe for both residents and staff. Residents 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".

A critical incident report completed by the home indicated an incident regarding the improper use of lifting equipment.

Interview with a Personal Support Worker(PSW) confirmed that an incident had occurred, and had been reported. An incident report was completed.

Two Personal Support Workers verified the home's expectation of staff involvement when using specific lifting equipment. The plan of care confirmed that the identified resident required the use of lifting equipment.

The DOC confirmed it was the home's expectation that the home's policy be complied with. [s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The homes policy titled "Abuse and Neglect - P-10", last revised March 10, 2016, stated "Any alleged, suspected or witnessed incident of abuse or neglect of a Resident is to be made to the Administrator/designate of the Home, who will immediately commence an investigation".

Clinical record review for an identified resident revealed an witnessed incident of resident to resident interaction of alleged abuse. The Nurse Manager was notified.

Interview with the Director of Care verified there was not an incident report nor did the Administrator/designate have an awareness of this incident. The DOC confirmed the home's policy was not followed as expected. [s. 20. (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 that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a criminal reference check was required before a licensee hired a staff member or accepted a volunteer, that the criminal reference check was conducted within six months before the staff member was hired or the volunteer was accepted by the licensee.

The Criminal Reference Check accepted by the home for a staff member had been conducted in excess of six months before the staff member was hired.

The Director of Nursing and the Program Manager confirmed that it was the home's expectation that the Criminal Reference Check was to be conducted within six months before the staff member was hired. [s. 215. (2) (b)]

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.