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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2016_493652_0014	032839-16	Resident Quality Inspection

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

NATALIE MOLIN (652), SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 24 and 25, 2016

The following critical incident (CI) inspections were conducted concurrently with the RQI: 010626-16 (related to an allegation of abuse)

During the course of the inspection, the inspector(s) spoke with director of nursing (DON), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), environmental service manager (ESM), clinical informatics manager, assistant to the Residents' Council and Family Council, residents and substitute decision makers (SDM).

During the course of the inspection, the inspector(s): conducted a tour of the home; observed medication administration, staff to resident interactions and the provision of care, resident to resident interactions; and reviewed resident healthcare records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #003's current advance directives dated August 8, 2015, revealed the resident was level four which indicated in the event of a sudden onset of a life threatening illness, the resident would be treated aggressively, transfer to an acute care hospital would be arranged immediately and cardiopulmonary resuscitation (CPR) would be provided by qualified staff, if available, and by ambulance personnel.

A record review of resident #003's progress notes revealed a discussion was held with the substitute decision maker (SDM) and the physician on June 9, 2016, indicating the daughter's wishes for resident #003 were to not have CPR, that the resident should have a natural death at the home, and the resident should not be transferred to hospital if the resident became dehydrated.

Interviews with registered nurse (RN) #100 and the director of nursing (DON) revealed resident #003's advance directives were not updated to reflect the most recent discussion between the SDM and the physician on June 9, 2016. Both RN #100 and the DON confirmed the expectation is for the written plan of care to be updated to provide clear directions to staff. [s. 6. (1) (c)]

Issued on this 9th day of February, 2017

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

Original report signed by the inspector.