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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## 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 |
|---|---|---|---|
| Jan 23, 2020 | 2020_644507_0002 | 014305-19, 024408-19 | 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

STELLA NG (507)

## 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): January 15, 16, 20 and 21, 2020.**

**The following intakes were inspected during this inspection:**
**Logs #014305-19 and 024408-19 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Personal Support Workers (PSW), Manager of Clinical Informatics, Physiotherapist (PT) and Private Care-giver.**

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

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of residents #002 and #003 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

a) An identified Critical Incident System (CIS) report was submitted to the Director on an identified date, in regards to resident #002's significant change of health status as a result of an incident.

Review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) for resident #002 completed on an identified date indicated the resident required a certain level of assistance for bed mobility and transfer. Review of the care plan for resident #002 completed 12 days later indicated to provide a different level of assistance for bed mobility and transfer.

In an interview, staff #106 stated that when completing the RAI-MDS, staff would review the seven days observation records and progress notes, and speak with the staff on how do they provide care to the resident, to ensure the coding is accurate; then update the care plan accordingly.

b) Due to identified noncompliance with LTCHA 2007, c. 8, s. 6 (4) (b), the sample of residents reviewed was expanded to include resident #003.

Review of the RAI-MDS for resident #003 completed on an identified date indicated the resident required a certain level of assistance for transfer. Review of the care plan for resident #003 completed on the same day indicated to provide a different level of assistance for transfer.

In an interview, staff #107 stated that when completing the RAI-MDS, staff should complete required assessments, speak with the team members, review the seven days observation record on the level of assistance the resident required, to ensure the coding is accurate; then update the care plan accordingly. Staff #107 further stated that the care plan should reflect the resident's care needs. Staff #107 acknowledged there was a lack of collaboration among the team members in the development of residents #002 and #003's above mentioned plans of care. [s. 6. (4) (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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.***

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**Issued on this 24th day of January, 2020**

[redacted]

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

**Original report signed by the inspector.**