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
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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
May 9, 10, 17, 2012	2012_077109_0019	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

SUSAN SQUIRES (109)

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 Care, Registered Nursing staff, Infection Control Coordinator, Family members, Personal Support Workers

During the course of the inspection, the inspector(s) Observed the care activities on the unit, reviewed the health record for an identified resident, reviewed the home's policies for g-tube and infection control,

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. A resident did not receive the g-tube feed as specified in the plan of care.
A resident receives a G-Tube feeding ordered to run continuously throughout the 24 hour period. A PSW staff member shut off the feed during care activities and neglected to report this to the charge nurse. The home's practice requires the PSW who shuts off the feed during care, to tell the charge nurse who is then responsible to turn the feed back on and ensure that it is running according to the plan.
The Nurse discovered the g-tube was shut off. The resident did not receive the G-tube feed for 2 hours.

Issued on this 4th day of June, 2012

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