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
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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
Nov 13, 14, 15, 16, 17, 19, 20, 2012	2012_159178_0009	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 LUI (178)

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 Director of Nursing (DON), Regional Manager for home's contracted maintenance company, Environmental Services Manager, Maintenance Staff, Registered Staff, Personal Support Workers (PSWs), a resident and the resident's family member.

During the course of the inspection, the inspector(s) observed residents' surroundings and furnishings, reviewed resident records, reviewed home policies and procedures, reviewed home's records of an abuse investigation.

The following inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Medication

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
During an inspection in November 2012 the inspector observed the following within the home:

-in the resident bathroom of an identified resident's room the baseboards had lifted from the wall in several spots, leaving the base of the drywall unprotected from water. After this was identified by the inspector, home staff began working to replace the baseboards.

-in an identified resident's room, on the ceiling between the window and the curtain rail the ceiling is open revealing broken drywall which appears to have been patched with foam insulation. The foam insulation is protruding out from the drywall. The Environmental Services Manager confirmed that this area of the ceiling has been open for at least a year following work to repair a ceiling leak. The leak was repaired and the Manager indicated that now that the area has remained dry for some time, the ceiling can be repaired.

-in the 2nd floor dining room, paint has peeled from the wall beneath the window. Also in the dining room, the inspector observed broken drywall (a divet where the drywall is pushed in forming a hole) on the wall beneath the call bell.

-the drywall in an identified resident's room is crumbling where it meets the baseboard, and the baseboard is lifted from the wall in this spot.
[LTCHA s. 15(2)(c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 142. Care during absence
Every licensee of a long-term care home shall ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence,
(a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home sets out in writing the care required to be given to the resident during the absence; and
(b) a member of the licensee's staff communicates to the resident, or the resident's substitute decision-maker,
(i) the need to take all reasonable steps to ensure that the care required to be given to the resident is received by the resident during the absence,
(ii) that the licensee will not be responsible for the care, safety and well-being of the resident during the absence and that the resident or the resident's substitute decision-maker assumes full responsibility for the care, safety and well-being of the resident during the absence, and
(iii) the need to notify the Administrator of the home if the resident is admitted to a hospital during the absence or if the date of the resident's return changer. O. Reg. 79/10, s. 142.

Findings/Faits saillants :

1. The licensee has failed to ensure that before a long-stay resident of the home leaves for a casual absence, a member of the licensee's staff communicates to the resident, or the resident's substitute decision-maker (SDM) the need to take all reasonable steps to ensure that the care required to be given to the resident is received by the resident during the absence.

Staff and family interviews confirm that on an identified date resident # 1 was sent home for a one day leave of absence (LOA). The resident's medications were sent home with the resident, however the Registered staff member on duty failed to inform the resident's SDM that one of these medications was to be "held" and not be administered to the resident for a specified number of days, as directed by the resident's physician. The resident was sent home with the medication which was not to be administered.
The resident's SDM was aware from another source that the medication was to be held and did not administer the medication to the resident.
The medication was "held" as specified by the resident's physician.

The staff member involved apologized to the resident's SDM, was disciplined by the home and received education regarding medication administration and the home's protocol for communication when sending residents out on a LOA. [O.Reg.142(b)(i)]

WN #3: 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. The licensee has failed to ensure that care for resident # 1 is provided as specified in the resident's plan of care for mobility.

Resident # 1 is wheelchair bound, and is able to propel his/her wheelchair throughout the unit.
Record review and staff interviews confirm that the resident is able to self propel in the wheelchair, and it is part of his/her plan of care for the staff to remove environmental barriers or obstacles so the resident can propel the wheelchair independently.
Interviews with the resident and his/her family indicate that furniture is sometimes left in or around the doorway of the resident's room, making it more difficult for the resident to propel his/her wheelchair through the doorway safely.
On various occasions during the inspection period in November 2012 the inspector observed various pieces of equipment or furniture stored around the doorway of the resident's room. These items included:
-a chair used by staff
-a walker
-an over-bed table
-an empty wheelchair
-a wheelchair containing another resident.

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 care for resident # 1 is provided as specified in the resident's plan of care for mobility, to be implemented voluntarily.

Issued on this 20th day of November, 2012

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

Susan Lui (178)