



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
prévus 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
Direction de l'amélioration de la performance et de la
conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
TORONTO, ON, M4V-2Y7
Telephone: (416) 325-9297
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8^{ième} étage
TORONTO, ON, M4V-2Y7
Téléphone: (416) 325-9297
Télécopieur: (416) 327-4486

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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 22, 23, 24, 25, 29, 30, Jun 4, 2012	2012_077109_0021	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 Staff, Personal Support Workers, Residents, Family members, Staff Education Coordinator

During the course of the inspection, the inspector(s) Reviewed the health record for an identified resident, reviewed staffing schedules and routines, reviewed continence supplies, reviewed continence program, observed care, reviewed complaints received by the home

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee received an email complaint from a family member complaining about disruptive behavior from another resident. The licensee did not immediately forward the complaint to the Director
2. The licensee failed to immediately forward a written complaint to the Director from another family member complaining about care of her mother.

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 when the licensee receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who is unable to toilet independently all of the time, received assistance from the staff to manage and maintain continence.

A resident states that he/she needs to wear diapers every day and the staff has to help them because they cannot get to the bathroom by themselves and he/she requires the standing lift.

The resident stated that they usually have to wait for either the lift or the bathroom and it can be as long as 1/2 hour and the resident has experienced incontinence episode in the past while waiting to use the toilet which he/she stated was quite embarrassing.

A resident stated that when they cannot get him/her to the bathroom fast enough, the staff tell the resident to go in the brief. The resident stated that this has happened in the past week.

The resident stated that the product (a brief) is not always available and the staff do not put the right size on.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home have received re-training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The Education Coordinator stated that for 2011 there were only 76 out of 196 employees re-trained in the annual zero-tolerance for abuse policy.

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 all staff are retrained in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101

(1).

Findings/Faits saillants :

1. The licensee failed to respond to the written complaint received from a family member regarding the care of her mother. The licensee did not investigate the complaint within 10 days.

There was no response to the complainant indicating what the licensee has done to resolve her complaint.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

(b) set out the organization and scheduling of staff shifts;

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to set out the organization of the part-time shifts of 7:00 am to 11:00 am, and 4:30 pm to 9:30 pm in terms of responsibility and routine.

There is no structured routine for the staff working on the part-time shifts. The documented routines are outdated and include assigned duties for the 7:00 to 11:00 am shift to be completed hours after the shift ends. The assigned residents include 6 residents, however when the staff were questioned they stated that only 4 residents are assigned. For mealtime assistance, it was unclear whether the part-time shift assisted residents.

Staff on the care units including the supervisory staff were unable to determine the specific duties and responsibilities for persons assigned to the part-time shifts of 7:00 am to 11:00 am and 4:30 pm to 9:30 pm.

WN #6: 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. (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

(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).

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 failed to ensure that the staff and others involved in the different aspects of care of a residents' pressure ulcer to the coccyx collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other.

There are inconsistencies among the disciplines in assessing the wound on the coccyx. It is unclear whether the wound was a Stage I or a Stage II.

November 1, 2010 - the Dietitian assessment note references a Stage II wound to coccyx.

November 4, 2010 - the RPN note references a Stage I wound to coccyx.

November 11, 2010 - another RPN note references a Stage II wound to coccyx.

November 12, 2010 - head-to-toe assessment references a Stage I wound to coccyx.

November 17, 2010 through to November 24 the wound to the coccyx is described as Stage I.

November 25, 2010 - weekly assessment describes a Stage II wound to the coccyx.

2. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in her plan.

The identified residents' plan of care for toileting stated preferences as follows:

a) Toilet upon getting up, after meals, before supper, and as per request.

b) Staff to ask resident if he/she wants to go to the toilet at the toileting times.

c) Resident will call.

d) Two person total assistance for entire process.

e) Use mechanical lift.

A progress note states that "resident awake and complained of wetness and claimed he/she had a BM. Very noisy and yelling and kept pointing to their bottom "something is wrong". Intervention included; checked the diaper and noted it was wet with no BM. Changed and peri-care given, repositioned and told nothing is wrong. Resident was not toileted. Another progress note states resident was shouting at the start of the shift at the top of her lungs. The resident continued to shout during care. Resident was not toileted.



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Issued on this 4th day of June, 2012

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

A handwritten signature in black ink, consisting of a stylized 'S' followed by a horizontal line.