Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: January 7, 2025
Inspection Number: 2024-1140-0003
Inspection Type: Proactive Compliance Inspection
Licensee: 848357 Ontario Inc.
Long Term Care Home and City: The O'Neill Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9-11, 13, 16-17, 2024.

The following intake(s) were inspected:

- Intake: #00133842 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that a door leading to a non-residential area was kept closed and locked when it was not being supervised by staff.

Rationale and Summary
The shower room door on a unit that was equipped with a keypad lock, was observed open and not being supervised by staff. Inside the shower room within the drawers of a storage bin was potentially harmful objects. During the observation, no resident walked past the unsupervised, open shower room door.

A Registered Nurse (RN) indicated that the shower room was a non-residential area

and the door leading to the shower room should have been kept closed and locked to restrict unsupervised access by residents.

The RN closed the shower room door and ensured it was locked on the same day after they were informed it was open.

Failure to ensure that the door leading to a non-residential area was kept locked and closed when it was not being supervised by staff put the residents at minimal risk.

Sources: Observations; interviews with the RN and Executive Director.

Date Remedy Implemented: December 10, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy made under section 267 of this regulation, was posted in the home.

Rationale and Summary
An observation revealed that the visitor policy was not posted in the home. The Social Services Coordinator (SSC) acknowledged that the visitor policy was not posted in the home.

The visitor policy was posted in the home the same day by the SSC.

Failure to have the visitor policy posted in the home provided minimal risk to the residents.

Sources: Observation; interviews with the SSC and Executive Director.

Date Remedy Implemented: December 10, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The license has failed to ensure the plan set out in the plan of care was provided to residents during meal service.

Rationale and Summary
1)A resident's care plan indicated they required specific interventions during meal time, however it was not provided to them.

A Personal Support Worker (PSW) acknowledged that the intervention was not provided to the resident during the lunch meal.

Failing to follow the plan of care increased the risk of harm to the resident.

Sources: Observations; resident's clinical records; interview with the PSW.

2)A resident's care plan directed staff to provide a specific intervention to them

during their meals, but the intervention was not observed.

A PSW acknowledged the intervention was not provided to the resident as stated in the care plan.

Failing to follow the plan of care increased the risk of harm to the resident.

Sources: Observations; resident's clinical records; interview with the PSW.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care were documented.

Rationale and Summary
The provision of care during mealtime for a resident was not accurately documented.

A PSW acknowledged that they documented the provision of care to the resident inaccurately.

There was increased risk of harm to the resident when staff failed to accurately document the provision of care.

Sources: Resident clinical records; interview with the PSW.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment that included pain for a resident.

Rationale and Summary
A resident was prescribed a specific treatment to manage their pain.

According to the Pain Lead, the registered staff were required to complete two pain assessments which were both not completed for the resident.

There was a risk that the resident's pain may not be managed and monitored effectively when the interdisciplinary pain assessments were not completed.

Sources: Resident's clinical records; and interview with Pain Lead.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that the home had a dining and snack service that included a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

Rationale and Summary
A resident's care plan stated that they required a specific nutritional intervention. However, staff were not aware and did not provide it to the resident during their meal.

The Dietary Services Manager (DSM) acknowledged that there was a potential gap in the meal service process regarding staff awareness of special diets and meal supplements.

There was increased nutritional risk to the resident when their nutritional intervention was not provided to them because staff were unaware of the dietary instructions.

Sources: Diet List, resident's clinical records; interviews with the DSM and others.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to comply with their meal temperature check policy to check meal temperatures at point of service.

In accordance with O. Reg 246/22, s. 11. (1) (b), the requirements of the licensee to ensure that food and fluids are being served at a temperature that is both safe and palatable to the residents must be complied with.

Specifically, staff did not comply with the policy "Meal Service Temperature Checks of Food," which stated that the Dietary Aide or cook was responsible for checking the temperatures of meals at the point of service for all diet types to ensure that the food was served at appropriate temperatures.

Rationale and Summary
During meal service, a DA was observed checking the hot food temperatures, but not the cold foods.

The DA acknowledged that they did not measure the cold foods as per the home's policy.

There was increased risk to the residents when the cold food temperatures were not checked prior to meal service.

Sources: Temperature logs, Meal Service Temperature Checks of Food Policy; interviews with the DA.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed as it related to hand hygiene practices, in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" 10.4 (h), related to support for residents to perform hand hygiene prior to receiving meals.

Rationale and Summary
A resident was not supported to perform hand hygiene prior to receiving their meal.

The resident and PSW both indicated that the resident was not provided support to perform hand hygiene prior to their meal.

The IPAC Lead indicated that there was increased risk of communicable disease transmission when the resident was not supported to perform hand hygiene prior to receiving their meal.

Sources: Observation; interviews with the resident, PSW, IPAC Lead, and Executive Director.

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and

optimizes effective drug therapy outcomes for residents.

The licensee has failed to ensure that their interdisciplinary medication management system provided safe medication management for residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the medication management system was complied with. Specifically, staff did not waste a resident's unused narcotic treatment immediately.

Rationale and Summary
The home followed Medisystem's policies and procedures for their medication management system. The Narcotics, Controlled and Targeted Substances policy indicated that all entries must be made at the time the drug is removed from the container and entries for wasted doses must be filled in completely with the signature of a witness and the wastage must be done immediately.

A Registered Nurse (RN) did not promptly dispose of the unused dosage after administering a narcotic to a resident.

A Nurse Manager (NM) acknowledged that the unused narcotic should have been wasted immediately to ensure safety.

There was was risk of harm to residents; and a risk of having unaccounted narcotics when the unused narcotic was not wasted immediately.

Sources: Resident's clinical records; observation; MediSystem Policies and Procedures; and interviews with NM and other staff.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure a medication cart was used exclusively for drugs and drug-related supplies in one resident home area (RHA).

Rationale and Summary
A non-drug-related package was stored in a medication cart. A RN acknowledged the package should not have been stored in the medication cart.

Failure to ensure that the medication cart was used exclusively for drugs and drug-related supplies may affect the home's safe storage of drugs practices in their medication management system.

Sources: Observation; interview with the RN.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement committee (CQIC) was composed of at least one employee of the licensee who has been hired as a PSW or provides personal support services at the home and meets the qualification of PSW referred to in section 52.

Rationale and Summary
The CQIC meeting minutes revealed there was no PSW mentioned as a member of the committee.

The Clinical Informatics and Quality Improvement Lead (CI-QIL) acknowledged the committee was missing a PSW member.

Sources: CQIC meeting minutes; interview with the CI-QIL.