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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 10, 2024

Inspection Number: 2024-1140-0002

Inspection Type:
Complaint
Critical Incident

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): September 12, 13, 16, 17, 18, 2024.

The following intake(s) were inspected:

- Intake: #00118549 / Critical Incident Systems (CIS) #2631-000010-24 was related to alleged abuse.
- Intake: #00124959 / CIS #2631-000013-24 was related to missing resident.
- Intake: #00126254 / CIS #2631-000014-24 was related to COVID-19 outbreak.

The following complaint intake was inspected:

- Intake: #00124924 was related to Safe and secure home.

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

Infection Prevention and Control
Safe and Secure Home
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 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 home has failed to ensure that Infection Prevention and Control (IPAC) standard, issued by the Director was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, specifically section 9.1 (e) i under Routine Practices directed the home to ensure environment controls, including location/placement of residents' equipment were in place.

The home was in a confirmed COVID-19 Outbreak on two floors at the time of the inspection.

Additional Precautions (AP) signages and waste receptacles for soiled linens were placed outside the identified residents' doors except for one. A Personal Support Worker (PSW) providing care for a resident acknowledged they did not have a waste receptacle readily available to dispose of linens.

The IPAC Lead and Director of Care (DOC) both acknowledged that lack of placement of residents' equipment was unsafe IPAC practice and there was a risk of infection transmission.

Failure to have residents' equipment for linen disposal readily available at point of care poses the risk of environmental control not being implemented.

Sources: IPAC Observations on two floors, review of Line List #3895-2024-00588, resident's electronic health records, Outbreak Management Team (OMT) Meeting dated September 10, 2024, IPAC Standard for Long-Term Care Homes, revised September 2023; interviews with the IPAC Lead and DOC and other relevant staff. [698]

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure a resident was treated with respect and dignity by a staff member.

Rationale and Summary

A resident expressed experiencing uncomfortableness, rudeness, and disrespect during interactions with a staff member.

The resident was reprimanded by the staff member for asking another staff member to assist them in going outside twice the day before for an activity.

The resident expressed that the experience left them feeling upset and had difficulties coping after the incident.

The DOC confirmed that the staff member was unprofessional towards the resident during the interaction.

Failure to ensure that the staff member treated the resident with respect and dignity resulted in a negative emotional impact to the resident.

Sources: Resident's clinical records, Critical Incident Report (CIR) # 2631-000010-24, Client Service Response (CSR) binder, Home's investigation, the home's policy titled, Resident's Bill of Rights, #RCSM P-05, interview with the resident, DOC and other relevant staff. [698]

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