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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 28, 2025

Inspection Number: 2025-1140-0001

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): January 21-24 and 27-28, 2025

The following intake(s) were inspected:

- Intake: #00130029 Critical Incident (CI) #2631-000018-24 - related to alleged staff to resident abuse
- Intake: #00132732 - complaint related to multiple care concerns

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 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 licensee has failed to ensure that a resident's plan of care related to their fall intervention was provided as specified in the plan. A resident's plan of care indicated that they were at high risk for falls and an intervention was to be used on a specified time of day.

Sources: A resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted a CI report to the Director when a resident complained of an alleged physical abuse from a staff. The home's investigation indicated that the staff was rough during care causing a resident to experience pain.

A staff acknowledged that the resident complained of pain. The home acknowledged that the abuse allegation was verified.

Sources: A resident's clinical records, resident and staff interviews.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 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 for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 7.3 (b) under the IPAC Standard for Long-Term Care Homes, the licensee has failed to ensure that IPAC audits were completed quarterly to ensure all staff can perform the IPAC skills required for their role. Specifically, there were no audits completed involving staff members from one of the home's department.

Sources: Home's IPAC audits, IPAC Standard (September 2023) and staff interview.