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

Public Report

Report Issue Date: July 16, 2025
Inspection Number: 2025-1140-0002
Inspection Type: 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): July 11 and 14 - 16, 2025.

The following intake(s) were inspected:

- Intake: #00144938 / Critical Incident #2631-000006-25 was related to fall of a resident.

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

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 the care set out in the plan of care for the use of a specific intervention, was not provided to a resident as specified in the plan.

A resident's care plan specified to use a specific type of intervention at all the times. The intervention was not noted in use during observation on two days. Resident Care Manager (RCM), Personal Support Worker (PSW), Acting Director of Care (DOC) and Registered Nurse (RN), acknowledged that the resident did not have the intervention as per the care plan.

Sources: Observations; review of the resident's care plan and interview with RCM, PSW, RN and Acting DOC.

WRITTEN NOTIFICATION: Plan Of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when, care set out in the plan had not been effective.

Review of Resident Assessment Instrument-Minimum Data Set (RAI-MDS) for the

past 10 months, noted that the resident required specific level of assistance for bathing care, but their care plan was not updated reflecting the required level of assistance.

Sources: Review of the resident's RAI-MDS and interview with RN, Acting DOC and Manager of Clinical Informatics.

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