

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:** January 8, 2026

**Inspection Number:** 2026-1140-0001

**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 dates: January 5 - 8, 2026.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00162189 - CI #2631-000021-25 was related to an allegation of physical/verbal abuse.
- Intake: #00164318 - CI #2631-000026-25 was related to an allegation of harm.

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

Responsive Behaviours  
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

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(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident required heightened monitoring. On a specific date, monitoring requirements were in place, however, the resident was left without heightened monitoring on two occasions during the day. The Behaviour Support Ontario (BSO) Manager acknowledged that staff should have not left the resident unattended.

**Sources:** Resident clinical records, observation and interviews.

### **WRITTEN NOTIFICATION: Behaviours and altercations**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 60 (b)**

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

A Personal Support Worker (PSW) was assigned to provide heightened monitoring on a specific date was not aware of the resident's responsive behaviours at the time of assignment. This resident required heightened monitoring due to their responsive behaviours which posed a potential risk to safety. The BSO Manager acknowledged that the assigned PSW should have been aware of this information.

**Sources:** Resident clinical records and Interview with PSW and BSO Manager.