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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Original Public Report

Report Issue Date: November 9, 2023	
Inspection Number: 2023-1215-0005	
Inspection Type: Critical Incident	
Licensee: St. Clair O'Connor Community Inc.	
Long Term Care Home and City: St. Clair O'Connor Community Nursing Home, East York	
Lead Inspector Joy Ieraci (665)	**Inspector Digital Signature** Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.11.10 11:48:23 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 3, 6 and 7, 2023

The following intake(s) were inspected:

- Intake #00091042, Critical Incident System (CIS), related to improper/incompetent treatment of a resident and;
- Intake #00092530, CIS, related to a disease outbreak.

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

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

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)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to personal care and transfers.

Rationale and Summary

The home submitted a critical incident for improper/incompetent treatment of a resident that resulted in harm to the resident.

The resident's plan of care directed that two staff were required to provide personal care and transfers with a mechanical lift, and that the resident could have responsive behaviours during care. The resident was found to have an area of altered skin integrity.

The day prior to the discovery of the altered skin integrity, a personal support worker (PSW) provided personal care and transferred the resident on their own with the mechanical lift.

The PSW was aware of the resident's plan of care and acknowledged that they provided care and transferred the resident on their own.

The Director of Care (DOC) verified that the PSW did not follow the resident's plan of care which resulted in the resident's injury.

The resident sustained an injury when the PSW did not follow the resident's plan of care.

Sources: Review of CIS report, the resident's clinical records and home's investigation notes, and interviews with the PSW, DOC and other staff. [665]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The home has failed to ensure that Additional Precautions were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, additional personal protective equipment (PPE) requirements including appropriate selection application as required by Additional Requirement 9.1 (f) under the IPAC standard.

Rationale and Summary

A resident was on additional precautions due to an infection.

The additional precautions signage on the resident's door indicated that eye protection was a required PPE when within two metres of the resident.

An Activation staff interacted within two metres of the resident without the required eye protection. The staff confirmed that they did not wear the required eye protection.

There was a risk of infection transmission to the Activation staff, other residents and staff when the required eye protection was not worn by the Activation staff.

Sources: Resident care observations, review of the resident's progress notes and additional precautions signage, and interviews with the Activation staff and other staff. [665]