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: March 1, 2023	
Inspection Number: 2023-1140-0002	
Inspection Type: Critical Incident System	
Licensee: 848357 Ontario Inc.	
Long Term Care Home and City: The O'Neill Centre, Toronto	
Lead Inspector April Chan (704759)	**Inspector Digital Signature** April W Chan Digitally signed by April W Chan Date: 2023.03.03 15:49:11 -05'00'
Additional Inspector(s) None	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 9-10, 13-14, 2023.

The following intake(s) were inspected:

- Intake: #00016558 related to unknown cause of injury

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applies to the long-term care home was carried out.

The licensee failed to ensure that a staff member carried out measures contained in the Ministry of Health COVID-19 Guidance document in accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 2022. Specifically, health care providers providing direct care with a suspected or confirmed case of COVID-19 should wear eye protection, gown, gloves and a fit-tested, seal-checked N95 respirator.

On February 10, 2023, a Personal Support Worker (PSW) provided direct care to a resident who was a confirmed case for COVID-19. The PSW wore eye protection, gown, gloves, and surgical mask while providing direct care. The PSW indicated that they usually wear an N95 respirator instead of the surgical mask while providing direct care to residents with confirmed case of COVID-19, but they had forgotten to. The Infection Prevention and Control (IPAC) lead indicated that the staff member should have worn an N95 respirator instead of a surgical mask during direct care of the resident who was a confirmed case for COVID-19.

The IPAC lead provided staff education for the resident's home area on when to choose personal protective equipment (PPE) and how to don and doff an N95 respirator and surgical mask.

There was low risk identified when a staff member wearing eye protection, gown, gloves, surgical mask, and not N95 respirator, provided direct care to a resident who was a confirmed case for COVID-19.

Sources: observations on February 10, 2023, interviews with a PSW and IPAC lead.

Date Remedy Implemented: February 10, 2023 [704759]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), the licensee shall make person protective equipment (PPE) available and accessible to staff and residents, appropriate to role and level of risk. Specifically, the licensee did not ensure an accessible supply of surgical mask was available to staff as is required by Additional Requirement 6.1 under the IPAC Standard.

On February 10, 2023, there was a PPE shelving unit located outside a resident's room posted with droplet and contact precautions. The PPE shelving unit had a plastic bag of surgical masks laid over top three boxes of gloves. A staff member passing by discarded the plastic bag containing surgical masks after asking around who the plastic bag belonged to.

A Registered Practical Nurse (RPN) stated that a supply of PPE, including surgical masks, was made accessible to staff by use of PPE shelves outside of a resident's room. They indicated that they placed a plastic bag containing a supply of surgical masks at the PPE shelves.

The RPN and IPAC lead was informed about the discarded supply of surgical masks from a PPE shelving unit. A supply of surgical masks was replaced at the PPE shelving unit the same day.

Sources: observations on February 10, 2023, interviews with an RPN and IPAC lead.

Date Remedy Implemented: February 10, 2023 [704759]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The resident's plan of care identified wandering. A PSW identified that the resident no longer wandered and used a wheelchair for locomotion. The plan of care identified showering assistance. The PSW identified specific hygiene-related care, including showering, that was not in the written plan of care. An RPN identified that the resident's care needs had changed and the plan of care should be revised.

The resident's care needs changed when they sustained an injury. An intervention to transfer the resident from bed to chair with a mechanical device was implemented. The resident was later reassessed by the home's physiotherapist (PT) and was identified to be able to bear weight and transfer with manual assistance. The PSW and the RPN also identified that the resident was able to transfer with manual assistance, but that was not in the plan of care. The RPN identified that the intervention to transfer the resident using a mechanical device was no longer necessary, and the plan of care should have been revised.

The RPN and a Nurse Manager (NM) was informed of the discrepancies of the resident's plan of care. The NM confirmed that the resident's plan of care was revised to reflect the resident's care needs at the time of inspection. The resident's plan of care was revised on February 13 and 14.

There was no risk identified when the resident's plan of care was not revised when the resident's care needs change or care set out in the plan was no longer necessary.

Sources: the resident's clinical notes and care plan, interviews with staff members, and NM.

Date Remedy Implemented: February 14, 2023 [704759]