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

Original Public Report

Report Issue Date: October 5, 2023
Inspection Number: 2023-1140-0003
Inspection Type: Critical Incident
Licensee: 848357 Ontario Inc.
Long Term Care Home and City: The O'Neill Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Nrupal Patel (000755)	Nrupal Patel Nrupal Patel 2023.10.06 16:38:21 -04'00'

Additional Inspector(s) Britney Bartley (732787)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-28, 2023

The following Critical incident (CI) intake(s) were inspected:

- Intake: #00085606: - related to an Injury of Unknown cause.
- Intake: #00094809 - related to an Injury from fall.

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

Resident Care and Support Services
Infection Prevention and Control
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 (10) (b)

The licensee has failed to ensure that resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary

Observation of a resident revealed that their bed was not properly positioned when observed in bed.

The resident's care plan indicated that their bed should be positioned at a specific height. Registered Practical Nurse (RPN) #101 confirmed that the resident's bed was not at the correct height.

Physiotherapist (PT) #102 assessed the resident and recommended their bed be kept at a height to facilitate ease of transfer in and out of bed. Nurse Consultant (NC) #105 acknowledged that the resident's care plan should have updated and revised.

Failure to ensure that the resident's care plan was kept updated and revised put them at risk of difficulty getting in and out of bed.

Sources: Observations, resident #001's clinical records, interviews with staff.

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WRITTEN NOTIFICATION: Plan Of Care

NC #002 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 resident as specified in the plan.

Rationale and Summary

On a specific date a resident sustained a fall that resulted in an injury and transfer to hospital. A review of resident's clinical records indicated they required staff to ensure that fall intervention was in place.

Observation of the resident indicated that the fall intervention was not implemented.

Registered Practical Nurse (RPN) #101 confirmed that a specific intervention was not implemented. Nurse Consultant (NC) #105 acknowledged that the resident's care plan was not followed when their falls prevention intervention was not implemented.

Staff not implementing the intervention puts the resident at risk for falls and related injuries.

Sources: Observation, resident #001's clinical records, interviews with staff.

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