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 4, 2024
Inspection Number: 2024-1140-0001
Inspection Type: Critical Incident
Licensee: 848357 Ontario Inc.
Long Term Care Home and City: The O'Neill Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.03.14 12:58:35 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 14, 15, 16, 21, 22, 23, 26, 2024

The following intake(s) were inspected:

- Intake: #00097745 - [Critical Incident (CI):2631-000011-23] - Fall resulting in an injury
- Intake: #00104950 - [CI: 2631-000014-23] - Medication error
- Intake: #00106876 - [CI: 2631-000002-24] - Influenza A outbreak

The following intake was completed in this inspection:

- Intake: #00101600 - [CI: 2631-000013-23] - Fall resulting in an injury

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

Medication Management

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reassessment, revision

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Rationale and Summary
A resident's care plan indicated a specific treatment. It was observed that the resident did not have this treatment in place. A Registered Practical Nurse (RPN) stated that the resident did not need the treatment any longer and acknowledged that the resident's care plan should have been revised to reflect this change. The Director of Care (DOC) stated that staff were expected to revise the care plan when the resident's need changed.

There was no risk to the resident when their care plan was not revised to reflect the change in care.

Sources: Resident's care plan, interview with RPN, and the DOC.

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WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected.

In accordance with the definition identified in section 7 of the Ontario Regulation 246/22 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A resident exhibited symptoms which were outside of their baseline. A RPN stated that they noted these symptoms early on their shift however they did not complete any assessment or implemented any interventions. They also stated that they witnessed the resident falling to the ground in the afternoon. As a result of this fall, the resident was transferred to the hospital where they were diagnosed with a significant injury. Nurse Manger/Falls Lead and the DOC both stated that when the resident exhibited change in status, RPN was required to complete an assessment and implement interventions for resident's safety.

Due to the inaction of the RPN when the resident had a change in their health status, the resident's safety was jeopardized leading them to have a fall.

Sources: Resident's clinical records, interviews with RPN, Nurse Manager/Falls Lead, and the DOC.

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WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirement set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed. The document required that masks be worn indoors in all resident home areas.

Rationale and Summary
(i) On February 14, 2024, a Program Therapist was observed exiting a resident's room with their mask below their chin. They stated that they had their mask below

their chin when they were inside the resident's room having a conversation. They acknowledged that they were required to keep their mask on at all times. Interim Infection Prevention and Control (IPAC) Manager stated that masks were to be worn properly inside the home.

Due to the home not ensuring that the masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: Inspector's observation, interviews with Program Therapist and Interim IPAC Manager, and COVID-19 guidance document for long-term care homes in Ontario last updated November 7, 2023.

Rationale and Summary

(ii) On February 16, 2024, an RPN, and Registered Nurse (RN) student were observed at the nursing station sitting beside each other with their masks below their chin. A Personal Support Worker (PSW) was observed closer to the nursing station with no mask. They all acknowledged that they were required to keep their mask on at all times. Interim IPAC Manager stated that masks were to be worn properly inside the home.

Due to the home not ensuring that the masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: Inspector's observation, interviews with the RPN, RN student, PSW and Interim IPAC Manager, and COVID-19 guidance document for long-term care homes in Ontario last updated November 7, 2023.
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WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by a resident at all times.

Rationale and Summary
A resident did not have access to their call bell. The observations were verified by a PSW and they stated that the resident was able to use the call bell.

The DOC acknowledged that the resident needed to have their call bell accessible to them at all times.

Due to the home failing to provide access to the call bell, there was a risk of the resident not receiving the assistance they required including in case of an emergency.

Sources: Inspector's observations, and interview with PSW and the DOC.

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WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;

The licensee has failed to ensure that cleaning and disinfection was in accordance with manufacturer's specifications.

Rationale and Summary
On February 14, 2024, inspector found a total of one expired cleaning disinfectant bottle in use by a housekeeper. The housekeeper acknowledged inspector's observation. Interim IPAC Manager stated that expired product should have been replaced.

Due to the home using expired disinfectant, there was a risk of infection transmission as the disinfectant may have been less effective against pathogens.

Sources: Inspector's observations, interview with housekeeper, and Interim IPAC Manager.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1(b & d) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) and Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary
(i) On February 14, 2024, a PSW was observed walking one resident by holding their

hand to the dining room, and assisting four other residents in their wheelchairs to the dining room. They did not perform hand hygiene with each before or after resident/resident environment contact and acknowledged inspector's observations. Interim IPAC Manager stated that the staff was required to perform hand hygiene before and after each resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with PSW and Interim IPAC Manager, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary
(ii) On February 14, 2024, Inspector found a total of three expired hand sanitizers in use. Interim IPAC Manager, acknowledged that the expired product should have been replaced.

Due to the Long-Term Care Home (LTCH) using expired hand sanitizers, there was a risk of infection transmission as they may have been less effective against pathogens.

Sources: Inspector's observations, interview with Interim IPAC Manager, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

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WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The Licensee has failed to that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary
A resident was administered multiple medications in error by an RN. These medications were not prescribed for the resident. As a result, the resident experienced side effects and was transferred to the hospital for further assessment and treatment.

RN stated that they did not verify the resident's identity to ensure that the medications were being administered to the correct resident. The DOC stated that the RN did not verify that the right resident was receiving the medication.

There was some harm to the resident when they received medication which was not prescribed for them.

Sources: Resident's clinical records, and interview with RN and the DOC.

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