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

Public Report

Report Issue Date: January 15, 2025
Inspection Number: 2025-1215-0001
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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 14, 15, 2025.

The following intake was inspected:

- Intake: #00130752 - Critical Incident System (CIS) #2719-000009-24 - related to a disease outbreak.

The following intake was completed:

- Intake: #00137081 - CIS #2719-000001-25 - related to a disease outbreak.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 4.3 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee along with the Outbreak Management Team (OMT) and the interdisciplinary IPAC team was to conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of an outbreak that occurred but did not.

Sources: Interview with the IPAC Lead; Review of the home's IPAC documents related to an outbreak.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to ensure that a report was made using the Ministry's method for after-hours reporting. An outbreak was declared and a Critical Incident System (CIS) report was submitted on the same day but after business hours. The home did not contact the after-hours line to report this outbreak.

Sources: CIS report #2719-000001-25; Ministry of Long-Term Care memo titled, "Reporting Requirements for LTC Homes", dated June 2023; Interview with the IPAC Lead.