Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 12, 2024
Inspection Number: 2024-1178-0003
Inspection Type: Critical Incident
Licensee: Omni Healthcare (Lambton) Limited Partnership, by its general partner, Omni Healthcare (Lambton) GP Ltd.
Long Term Care Home and City: Bear Creek Terrace, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22, 23, 2024

The following intake(s) were inspected:

- Critical incident related to a failure/breakdown of the resident-staff communication and response system.

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

Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and secure home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
ii. equipped with a door access control system that is kept on at all times, and

The licensee has failed to ensure that the following was complied with:

All doors leading to the outside of the home, specifically the main entry door, must be equipped with a door access control system that is kept on at all times.

Rationale and Summary

The main entry door leading into and out of the home was not kept on at all times, or locked. The sliding door was not equipped with a keypad, which had been removed in June, 2024. The keypad was part of the door access control system, allowing visitors, staff, and residents into and out of the home by using a code to release the magnetic locks. Without the keypad, the door was able to open and close without any restrictions.

The Environmental Services Manager (ESM) explained that the keypad had to be physically removed as contractors could not repair it while on site. It was therefore sent out for repair. According to the Acting Administrator, the keypad was replaced and functional 37 days later.

Sources: Observations, interviews with the ESM and the Acting Administrator.

WRITTEN NOTIFICATION: Safe and secure home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii. A.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system

The licensee has failed to ensure that the following was complied with:

All doors leading to stairways and the outside of the home must be connected to the resident-staff communication and response system.

Rationale and Summary

The main entry door leading into and out of the home and two stairwell doors on the Fairbanks home area were not connected to the resident-staff communication and response system (RSCRS). The Environmental Services Manager (ESM) and acting Administrator were not aware that the stairwell doors were not functioning as required. When tested during the inspection, the ESM confirmed that the location of the doors did not display on the nursing staff phones, which were part of the RSCRS. The ESM explained that they were routinely tested and that both the door access

control system and the RSCRS were also monitored remotely by an external company. However, the company had not received an alert that either system was not functioning as required.

Sources: Observations, interviews with the ESM and the Acting Administrator.

WRITTEN NOTIFICATION: Safe and secure home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 4.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
4. Any locks on bedrooms, washrooms, toilet, or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

The licensee has failed to ensure that any locks on washroom doors were maintained so that they could be readily released from the outside in an emergency.

Rationale and Summary

Two common use washroom doors were observed to be designed with an interior thumb turn dead bolt lock on the inside of the washroom door. The outside or corridor facing side of the door included a face plate with a small hole in it. The hole required a release key (shaped like a T) to release the deadbolt lock in an emergency. A registered nurse in one of the home areas did not have the release key available to them and was not aware if anyone else had one.

Failure to ensure that washroom doors can be readily released from the outside in an emergency will hinder staff response time to reach the resident, staff, or visitor.

Sources: Observations (doors tested), interview with the acting Administrator and RPN.

COMPLIANCE ORDER CO #001 Maintenance services

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall be compliant with O. Regulation 246/22, s. 96 (1) (b).
Specifically, the licensee must:
1. Develop written preventive maintenance procedures that are home-specific to Bear Creek Terrace for furnishings, fixtures, equipment, operational systems (hot water and potable water supply, cooling, heating, ventilation, resident staff communication and response system, fire safety systems, lighting, drainage, door access control systems), and surfaces (roof, doors, walls, floors, windows, ceilings).

2. Include in each procedure a minimum of the following information:
a) Who is responsible for monitoring the equipment, surface, fixture, furniture, surfaces, or system (whether home staff or an external service provider) and how

often;
b) What forms or checklists are to be completed to assist with any monitoring task
c) What the staff member is required to do, observe or test based on their skill level and manufacturer's requirements;
d) The required or acceptable condition of the equipment, surface, fixture, furniture, or system (derived from the manufacturer, prevailing or best practices, building, electrical & fire code requirements, CSA standards, etc.);
e) Follow up requirements if an unacceptable condition is identified and any documentation requirements;
f) Acceptable time frames, based on risk, for repair or replacement; and
g) Any additional tasks as required to maintain the fixture, surface, equipment, system, and furniture in a good state of repair.

3. Develop an audit or checklist that includes resident spaces, utility rooms, tub and shower rooms, and common areas. Each space shall be inspected routinely for condition and include the surfaces, fixtures, equipment, and furnishings in each space. Any deficiencies identified shall be dated and an action plan developed to address the deficiency.

4. Conduct an audit of the resident rooms, all washrooms, common areas, tub and shower rooms and utility rooms using the developed audit form or checklist to determine what additional deficiencies require attention that have not been identified in the grounds below. The audit results shall be maintained for one year and include who conducted the audit(s), what was identified, the date of the audit(s), course of action that was taken to address the deficiency and the date the deficiency was resolved.

5. Provide the inspector with an action plan that lists the deficiencies identified in the grounds below and include who will be responsible for addressing the

maintenance deficiencies and the proposed allocated time to complete the work.

Grounds
The licensee has failed to ensure that as part of the organized program of maintenance services under clause 19 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee adopted just over a year ago, maintenance procedures and schedules from an external service provider who offered consulting and management services. The service provider developed only one preventive maintenance policy and one checklist (to be completed monthly) for maintenance staff to use when evaluating the condition of the building surfaces, fixtures, equipment, and systems generally found in a long-term care home. The procedure associated with the policy included direction to use a checklist and complete preventive maintenance monthly and to ensure that the licensee had a work-order based system to manage the home's maintenance program in place. No daily, weekly, or annual audits or checks were mentioned. The checklist was designed so that the maintenance staff were required to answer "yes" or "no" as to whether all of the fixtures, surfaces, systems, or equipment in the building were in good condition or functioning properly. For the months of May, June and July 2024, the checklists were completed with a "yes" 90% of the time.

According to the maintenance staff and Environmental Services Manager, all fixtures, surfaces, systems, and equipment on the checklist could not possibly be checked each month. Maintenance staff also confirmed that there were no focused preventive maintenance checklists developed to audit or check each resident room, common area or staff-only spaces for overall condition and that window screens, windows, flooring, and light fixtures were so far the only audits completed in 2024. There were no preventive maintenance checklists for the resident-staff

communication and response (RSCR) system, or door access control system which included what components/hardware were checked and to determine if each door, call station, keypad, magnetic lock, and dome light in the home were functional and if either call station or door were triggered, that they connected to the RSCR system.

No written procedures to guide maintenance staff were developed for maintaining the furnishings, surfaces, systems, fixtures, or equipment in the home.

The licensee purchased a software program identified as "Maintenance Care" which included the ability for staff to enter information related to disrepair as part of their remedial maintenance program. Fifteen preventative maintenance scheduled tasks for the maintenance employee to complete, either daily, monthly, or bi-annually were also included, but the list was not all encompassing. No procedure was developed regarding how staff (including maintenance staff) were to generally use the system. Maintenance staff noted that staff do not always enter an area of despair into the system for follow up and preferably identify issues to maintenance staff verbally.

Observations included the following at the time of inspection;

- The call stations related to the resident-staff communication and response system were not functional outside in the courtyard or on a balcony in an identified home area. The call stations were noted to be spring-loaded red push buttons which did not function when tested and were not connected to the phones (which were part of the RSCRS) carried by care staff. The buttons were not typical of a call station design normally used. The acting administrator and the Environmental Services Manger were not aware that the red push buttons were not functioning as required.

- A shower fixture in one home area was leaking and had a towel wrapped around it. A light was also burnt out in the shower, which was fairly dark. Staff had not entered the information into the Maintenance Care system and maintenance staff were not aware of the issues.
- A call station powered by a battery in a bathroom near the conference room was not functional. According to the ESM, batteries were monitored by a system to alert staff when they needed to be changed before they died. The system did not appear to have been monitored by a staff member or the system did not sense that the battery had died.
- Resident bedroom door frames and some frames inside of resident rooms included cracked or missing plastic protective moldings. The frames appeared heavily rusted (due to contact cement used) and some of the plastic was sharp and sticking outwards, a potential safety risk for staff and residents.
- Overbed light pulls were not accessible to residents in each room, as the pulls were approximately 2 inches in length. The cording for the pulls were removed or not replaced.
- Walls were heavily scuffed or marked from wheelchairs and other equipment in resident bedrooms and washrooms. No routine painting program was in place for the home with the exception of resident rooms that became vacant. Spaces that were painted by maintenance staff were not documented.
- Furnishings were observed to be in poor condition throughout the home. Wooden end tables with cracked, scratched or worn surfaces were observed in corridors in three different home areas. Two red sofa chairs in one identified home area had deep scratches on the arms and seat cushions.

Failure to develop, implement and comply with the maintenance program schedules and procedures has created conditions in the home which do not align with the fundamental principle under the Fixing Long Term Care Act to promote high quality accommodation to live in a safe and comfortable environment.

Sources: Observations, interview with the Environmental Services Manager, maintenance staff, acting Administrator, review of policy ENV-MTC-2.1 (Feb. 4, 2022) *Preventive Maintenance Program*, *Monthly Preventive Maintenance Checklist*, focused audits for 2024, and Maintenance Care software program and associated tasks.

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg. 246/22, s. 102 (2) (b)
Specifically, the licensee must;

1. Develop a written policy and procedure, in consultation with the home's IPAC lead, that deals with how to handle, store and clean and disinfect non-critical reusable medical devices such as wash basins, bed pans, urinals and commode pots in accordance with any of the following best practices Frequently Asked Questions (FAQ) on Bath Basin Use in Long-Term Care Facilities | Agency for Healthcare Research and Quality (ahrq.gov), PIDAC: Best Practices for Environmental Cleaning for Prevention and Control of

Infections | January 2018 (publichealthontario.ca) page 140 and WRHA Infection Prevention & Control Program.

2. Once developed, all care staff who use the reusable medical devices shall receive face to face training and any demonstrations with respect to the written policy and procedure. Maintain an attendance list, date and time training was provided and who provided the training.
3. Develop an audit form that includes what practices, products and supplies the IPAC lead or designate will be required to review related to the handling, storage, cleaning and disinfecting of non-critical reusable medical devices by care staff in resident spaces and in soiled utility rooms.
4. Complete the audit form quarterly and maintain the records for review.

Grounds

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard (revised September 2023) issued by the Director. Specifically, sections 5.3 (h), and 7.3 (b) of the IPAC Standard were not implemented.

Rationale and Summary

Section 5.3 (h) requires that the IPAC program include cleaning and disinfecting policies and procedures related to implementing routine practices. Routine practices include cleaning and disinfecting resident's reusable medical equipment (e.g., basins, urinals, commodes, bed pans, etc.). The licensee identified that they referred to a policy and procedure developed by their consulting and management service. The procedure however did not include any direction for care staff other than to use a ready-to-use disinfectant wipe on resident's dedicated equipment and follow the manufacturer's instructions for use. Secondly, the procedure directed staff to review a best practice document which did not include any specific handling or storage instructions. The policy and procedure identified that the dedicated

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equipment was to be placed on a weekly cleaning schedule. No details were included about where exactly the equipment was to be cleaned, with what cleaning equipment, products, or by whom.

Two personal support workers were not aware of the best practices related to cleaning and disinfecting reusable medical equipment. The wash basins were normally rinsed and allowed to air dry after each use. No specific cleaning and disinfection process was employed. During the inspection, wash basins and bed pans were observed stored inappropriately on towel and grab bars in resident washrooms, and some did not appear clean. One basin had what appeared to be white toothpaste on the surface over a two-day period. The soiled utility rooms were not set up for adequate cleaning and disinfection processing. No disinfection products were made readily available to care staff while in resident care areas. The workers identified that disinfectant wipes were available in some resident rooms or on linen carts in the corridors. No disinfectant wipes were located on linen carts in two home areas.

Failure to develop and implement cleaning and disinfection procedures for staff to follow increases inconsistent routine practices and the risk of disease transmission.

Section 7.3 requires the IPAC lead to perform (at least quarterly) audits to ensure that all staff can perform the IPAC skills required of their role. The IPAC lead acknowledged that they did not perform audits regularly to determine if personal support workers were cleaning and disinfecting reusable medical devices, as required by their role. The audits that were completed consisted of whether or not basins were labelled and stored in resident washrooms or bedside tables.

Failure to conduct quarterly audits to determine if care staff are cleaning and disinfecting reusable medical equipment (which is part of the role of personal

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support workers) in accordance with best practices increases the risk of disease transmission.

Sources: Observations, interview with the IPAC lead, RPN (back-up for the IPAC lead), personal support workers and review of Policy IPAC-RM-10.2 (Feb. 24, 2023) *Reprocessing,* and IPAC audits.

This order must be complied with by October 31, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email

or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.