Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: January 27, 2025
Inspection Number: 2024-1178-0005
Inspection Type: Follow up
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): January 20, 21, 22, 2025

The following was completed:

- Follow-up to Compliance Order #001 related to maintenance services.
- Follow-up to Compliance Order #002 related to the infection prevention and control program.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1178-0003 related to O. Reg. 246/22, s. 102 (2) (b)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1178-0003 related to O. Reg. 246/22, s. 96 (1) (b)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe environment for its residents.

Three gas fireplaces were observed to be in use during the second day of inspection within two identified home areas and a common area outside of one of the home areas. All three were too hot to touch without burning the skin and had heat emanating into the spaces. Residents were sitting around the fireplaces in the two home areas. A registered staff member in one of the home areas was not aware of how to turn off the fireplace when asked. On the following day, all fireplaces, including one in a third home area were observed to be shut off. Action to have the gas line disconnected and/or to cover the controls with a lock box were initiated.

A bedroom located in an identified home area was not adequately secured against

resident entry after it was deemed a possible safety hazard at the end of December 2024. Yellow caution tape was placed across the door frame but did not prevent the door from being opened or the room from being entered. A lock for the door had not been installed to prevent unauthorized access. A large area of the ceiling in the room was exposed to a water leak from the roof at the end of December 2024, and had affected the integrity of the ceiling in the room. Two residents were relocated to avoid any possible safety risk.

Sources: Observation and interview with the Infection Prevention and Control (IPAC) lead and Administrator.

WRITTEN NOTIFICATION: Licensee to comply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the conditions of Compliance Order (CO) #001 from inspection #2024-1178-0003 related to maintenance services under s. 96 (1) (b) of O. Regulation 246/22, served on August 12, 2024, with a compliance due date of October 31, 2024.

The following components of the order were not compliant;

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.

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 procedures were in place for routine, preventive and remedial maintenance.

The licensee developed one maintenance policy which identified that building systems, medical equipment, medical devices, tools, vehicles, operating equipment, vehicles and technological systems and devices needed to be maintained. No details of how this would be accomplished for each of the items was identified. No information was included about maintaining the home and furnishings. A monthly checklist (which is not the equivalent to procedures) with numerous equipment, systems, some surfaces, and resident beds was included for staff to complete, but did not include furnishings. Alternatively, the licensee's software program which included a schedule for preventative audits for various equipment and systems, did

include some tasks for maintenance staff to follow, but were not procedures.

A monthly audit procedure for dining rooms, common areas, utility rooms, tub and shower rooms and bedrooms with accompanying checklists were developed for joint health and safety, dining, and housekeeping staff. The procedures outlined roles and responsibilities for staff in identifying and reporting deficiencies. However, procedures were not developed specifically for the building systems (HVAC systems, plumbing, lighting, communication and response system, door access controls, hot water, etc.), the home (exterior and interior areas), furnishings and equipment (used by dietary, nursing, housekeeping, maintenance, activation staff) which included prescribed expectations to be undertaken to maintain the systems, furnishings, equipment, and surfaces in good repair.

Sources: Interview with the Administrator and IPAC lead, review of monthly audit procedures for dining rooms, common areas, utility rooms, tub and shower rooms, existing maintenance policies and procedures, maintenance software application and associated records.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is

being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

Compliance Order (CO) #001 from inspection #2024-1178-0003 related to maintenance services under s. 96 (1) (b) of O. Regulation 246/22, was previously served on August 12, 2024, with a compliance due date of October 31, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii.
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

The licensee has failed to ensure that all doors leading to the outside of the home, to which residents had access, specifically the main entry door and side exit door from an identified home area, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

Sources: Observations and interview with the Administrator.

WRITTEN NOTIFICATION: Doors in a home

NC #004 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 all doors leading to the outside of the home, to which residents had access were connected to the resident-staff communication and response system. (RSCRS)

The front entry door to the home was not connected to the RSCRS. The system was comprised of portable phones carried by staff which would display the location of active call stations and exit doors when they remained open. However, the front door, when tested, was not programmed to the portable phones. An exit door in an identified home area was locked at the time of inspection and could not be tested. The maintenance manager nor the administrator could open the door for testing as they were unaware of the key code to disengage the magnetic lock. Staff did not use the door and management staff were not aware if it was connected to the

RSCRS.

Sources: Observations and interview with the Administrator.

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
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,
(f) clearly indicates when activated where the signal is coming from

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

The call stations located in a hair salon and a resident common washroom within an identified home area did not display on the visual/audio panel at the nurse's station, did not trigger the dome lights or the audio system within the corridors when activated. As such, staff were not aware that call stations had been activated and could not respond.

Sources: Observations, review of maintenance audits for the RSCRS and interview with the Administrator.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following

incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security, or well-being of one or more residents for a period greater than six hours.

The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

An environmental hazard that affected the provision of care or the safety, security, or well-being of one or more residents for a period greater than six hours.

Two residents had to be re-located from their room following a roof leak that affected the ceiling integrity in their room. Both residents were accommodated in other rooms within the home at the end of December 2024, to assure their safety. The room was vacant during the inspection and would remain so until roof repairs can be completed when weather permits. The management staff who were working at that time were not certain if the incident warranted reporting.

Sources: Observations, interview with the Infection Prevention and Control Lead and the Administrator.