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

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Public Report

Report Issue Date: May 9, 2025

Inspection Number: 2025-1178-0004

Inspection Type:
Proactive Compliance Inspection

Licensee: Omni Quality Living (Lambton) Limited Partnership by its general partner, Omni Quality Living (Lambton) GP Ltd.

Long Term Care Home and City: Bear Creek Terrace, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2025 and May 1, 2, 5-9, 2025

The following intake(s) were inspected:

- Intake: #00145280 - Proactive Compliance Inspection - 2025

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
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,
i. kept closed and locked,

The licensee has failed to ensure that all doors leading to the outside of the home or doors that residents do not have access were kept closed and locked.

During an initial tour of the home on April 29, 2025, the Inspector was able to access emergency exit door #3 which lead to another unsecured door leading outside. During an audit completed by the home, it was identified that the door was not securely latching at times. A sign was posted on both sides of the door notifying staff to ensure the door was pulled closed after entering. The door was fixed by the home on April 30, 2025.

Sources: Observations, record review and interviews with the home's staff.

Date Remedy Implemented: April 30, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that three doors leading to non-residential areas were kept locked when they were not being supervised by staff.

During an initial tour of the home on April 29, 2025, the Inspector was able to access a soiled utility room on Ruby Hall, a clean utility room on Victoria Way, and the Ruby Hall servery as it had a broken keypad. During an audit completed by the home, it was identified that some of the locking mechanisms of the coded doors had been unlocked. A memo was distributed to staff regarding the concern and labels stating "do not unlock" were applied to all doors with locking mechanisms. The home replaced the broken keypad on the servery door on April 30, 2025.

Sources: Observations, record review, and an interview with the Executive Director.

Date Remedy Implemented: April 30, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Reference to the "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings" from the Ministry of Health, states that "Alcohol-Based hand rubs (ABHR) are the first choice for hand hygiene when hands are NOT visibly soiled" and "must not be expired"

The licensee failed to ensure that Alcohol-Based Hand Rub (ABHR) in dispensers was not expired, as an observation completed on the Ruby Hall and Barclay home areas and a hallway leading to an exit from the home on April 29, 2025, identified ABHR in dispensers with an expiry date of April 4, 2025.

A subsequent observation completed on April 30, 2025 identified new ABHR in the dispensers with an expiry date of December 5, 2027.

Sources: Observation of Ruby Hall and Barclay home area and a hallway leading to an exit, review of the "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings"

Date Remedy Implemented: April 30, 2025

WRITTEN NOTIFICATION: Air temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure the home was maintained at the required temperature. A review of an air temperature report for the Ruby Hall dining room from May 5, 2025, showed temperatures ranging from 19 - 23 degrees Celsius, over 20 temperatures were noted below 22 degrees Celsius. On May 7, 2025, a Ruby Hall floor plan, pulled from the homes building automation system, showed eight temperature readings below 22 degrees Celsius at various locations throughout the home area.

Sources: Air temperature reports.

WRITTEN NOTIFICATION: Air temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee failed to ensure temperatures that were measured were documented in writing. During an interview with staff, they indicated the home had no records available of air temperature measurements. The staff shared that the home has a building automated system for monitoring temperatures but that the system, nor the home staff, were keeping a written record of temperatures as required for the identified areas.

Sources: Staff interview.

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with their pain management program.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure there is a pain management program to identify and manage pain in residents, and this program must be complied with.

Specifically a resident was noted to have a 7-day Pain Assessment in Advanced Dementia (PAINAD) assessment started March 20, 2025. The assessment was required to be completed every shift until March 26, 2025. Out of the twenty-one

required assessments, eleven assessments were not completed. The home's Pain Assessment policy, OTP-PM-5.3, last revised and approved March 5, 2025, stated that residents with an established CPS of 3 or higher shall be assessed using the PAINAD assessment tool.

Sources: Review of the resident's Point Click Care (PCC) assessments and progress notes. Review of the home's Pain Assessment policy (OTP-PM-5.3); Interviews with Director of Care (DOC).

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident had their wound reassessed weekly. A record review revealed that the resident was documented to have a Skin and Wound Evaluation completed on March 16, 2025, 10 days after the previous assessment on March 6, 2025, another evaluation was completed on April 10, 2025, 21 days after the previous assessment dated March 20, 2025, and a third assessment completed April 26, 2025, 16 days after the previous assessment dated April 10, 2025.

Sources: Skin and Wound Evaluations and staff interview.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that the food production system, at a minimum, provided communication to residents and staff of any menu substitutions.

During an observation on April 30, 2025, at 11:00am the posted lunch menu stated crab cakes or chicken caesar ranch sandwich, however at 12:00pm residents were being offered and served fish sticks not crab cakes as the posted menu stated.

An interview with a staff member confirmed on April 30, 2025, at 12:54pm that the lunch menu substitution from crab cakes to fish sticks had not been communicated to residents.

During an interview with a resident, on April 30, 2025, at 12:30pm confirmed they had not been communicated the lunch menu substitution for April 30, 2025.

Sources: Observations of lunch meal service, interviews with staff and resident, record review of posted weekly and daily menu for April 30, 2025.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (4) (c)
Food production
s. 78 (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 246/22, s. 78 (4).

The licensee has failed to maintain, and keep for at least one year, a record of, menu substitutions.

During an observation on April 30, 2025, at 11:00am the posted lunch menu stated crab cakes as choice one or chicken caesar ranch sandwich as choice two, however at lunch, residents were being offered and served fish sticks opposed to crab cakes per the post lunch menu.

A staff member confirmed during an interview on May 1, 2025, at 11:03am, that the home had not been keeping records of the posted menu substitutions for the year.

Sources: Observations of lunch meal service, interviews with staff and resident, record review of posted weekly and daily menu for April 30, 2025.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure that a resident was provided with assistive devices required to safely eat and drink as comfortably and independently as possible.

The resident's care plan in point click care (PCC) and dietary sheets dated April 29, 2025, and May 2, 2025, directed staff to provide the resident with the required adaptive aids.

An interview with the Registered Dietician (RD) on April 30, 2025, at 12:00pm, confirmed the resident required adaptive aides during meals which were identified in the care plan and on the dietary sheets used by kitchen staff and PSW's when serving meals.

May 5, 2025, at 12:25pm, the resident, was observed to have one of the adaptive aids, however, they were not provided with the second aid.

Sources: Observations of lunch meal service on April 30, 2025, and May 5, 2025, interviews with staff, record review of the resident's care plan dietary sheets in PCC.