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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: November 16, 2022	
Inspection Number: 2022-1319-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn	
Long Term Care Home and City: Forest Hill, Kanata	
Lead Inspector Lisa Cummings (756)	**Inspector Digital Signature**
Additional Inspector(s) Sarah Bradshaw (740814) Sarabjit Kaur (740864)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 26-30, and October 3, 2022.

The following intake(s) were inspected:

- Intake #00001470 (CI #2834-000009-22) and intake #00003161 (CI #2834-000001-22) were related to falls that caused injury and required transfer to hospital
- Intake #00006039 (CI #2834-000021-21) was related to a medical event that resulted in transfer to hospital
- Intake #00007293 (CI #2834-000008-22) was related to an allegation of abuse
- Intake #00006066 a complaint that was related to staffing

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

Medication Management

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Infection Prevention and Control
Staffing, Training and Care Standards
Prevention of Abuse and Neglect
Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to the use of signage for additional precautions and the use of personal protective equipment (PPE) in additional precaution rooms was complied with.

Section 9.1 of the Infection Prevention and Control (IPAC) Standard for long-term care homes stated that additional precautions shall include point-of-care signage indicating enhanced IPAC control measures are in place and that additional PPE requirements including appropriate selection, application, removal and disposal are used.

A resident was observed with a visitor in their room who had a medical mask donned. There was a supply of PPE on the door but additional precaution signage was not in place. A PSW stated that the resident required additional precautions. Further observation of the resident's room were conducted and another PSW was observed assisting the resident with a meal while wearing an apron and a blue medical mask. The PSW acknowledged the additional precaution signage now in place but stated the additional PPE was only required during personal care, not when assisting the resident with a meal. The IPAC Lead was interviewed and identified this was not the correct use of additional precautions for this resident. The IPAC Lead stated that additional PPE was required when assisting the resident with their meal and for visitors in the room.

A second resident's room was observed to have additional precaution signage in place. The PPE supply was on the back of the resident room door and the doffing bins in the room were not in use. A PSW stated the resident no longer required additional precautions and staff were not

using the additional PPE or the doffing bins as a result. However, the IPAC Lead confirmed that the resident continued on additional precautions and that they would follow-up with staff regarding the additional precaution requirements.

The failure to have additional precaution signage in place and ensure the use of required PPE in additional precaution rooms increased the risk of disease transmission.

Sources: Observations of resident rooms, resident healthcare records, and interviews with PSWs and the IPAC Lead.

[756]