Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2021	2021_861194_0014	021078-20	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

Streamway Villa
19 James Street West Cobourg ON K9A 2J8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 22 and 25, 2021

Inspected Log #021078-20, related to a resident fall.

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Environmental Services Manager (ESM), Life Enrichment Aide (LEA) and Housekeeper.

During the course of the inspection the inspector; Observed staff to resident provision of care, medication pass, meal service, room air temperatures and IPAC practices. The inspector reviewed the clinical health records for identified residents, Universal Masking policy and air temperature policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the Infection Prevention and Control Program (IPAC)

Review of the home's, Universal Masking policy stated that when providing care for a resident on droplet and contact precautions, masks must be changed after each resident interaction or upon leaving the resident's room.

RPN #106 confirmed that resident #006 was placed under droplet and contact precautions as they were symptomatic. Housekeeper (HK) #105 was observed cleaning in a resident room, identified with signage for droplet and contact precautions. Residents #006 and #007 were inside the room with HK, who was wearing, a gown, gloves and a mask while cleaning. HK was observed within six feet of resident #006 while in the room. It was observed that the privacy curtain between the residents was not pulled out. HK confirmed that goggles should have been worn. PSW #108 was observed entering the room with full personal protective equipment (PPE). When leaving the room the PSW removed all PPE except for their mask. The PSW confirmed that they were not required to remove their mask. PSW #109 entered the resident's room to assist PSW #108, without putting on any PPE. Failing to participate in the implementation the IPAC program, increases the risk of infection.

Sources: Observation of IPAC practice, review of Universal Masking Policy and interviews. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

Issued on this 27th day of October, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.