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

Central East District
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Original Public Report

Report Issue Date: November 14, 2022	
Inspection Number: 2022-1172-0001	
Inspection Type: 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: Streamway Villa, Cobourg	
Lead Inspector Jennifer Batten (672)	**Inspector Digital Signature**
Additional Inspector(s) Patricia Mata (571)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3-7, 12 and 13, 2022

The following intake(s) were inspected:

- Two intakes related to allegations of staff to resident abuse.
- One intake related to a resident fall resulting in a fracture.

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Infection Prevention and Control
Food, Nutrition and Hydration
Medication Management

Housekeeping, Laundry and Maintenance Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutrition and Hydration

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 9.

The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents #003, #006, #010 and #011, who each required assistance with eating.

Rationale and Summary:

Resident #003 was observed during the lunch meal. The lunch meal had been served to the resident while they were in bed and the head of the bed was left in a flat position, which caused the resident to attempt to eat while still lying flat and reaching up to the overbed table for the food items. During an interview, Restorative Care Aide (RCA) #100 indicated the resident should be in an upright position for food and fluid intake, entered the resident's room and asked the resident if they were OK, then exited the room without repositioning the resident's bed or making a recommendation to the resident about sitting up while eating and/or drinking, when the resident indicated they were fine.

Resident #006 was observed during the lunch meal while not seated in an upright position. Staff member #103 indicated that was the usual position for the resident, even during food and fluid intake.

On two specified dates, resident #010 was observed during the lunch meal while not seated in an upright position and being assisted by PSW staff. During an interview, the PSW indicated the resident should be in an upright position for food and fluid intake and repositioned the resident into an upright position for the rest of the meal.

Resident #011 was observed during the lunch meal. The lunch meal had been served to the resident while they were in bed, the head of the bed was not in a fully raised position, the resident was lying on their right side and was being assisted by Health Care Aide (HCA) #109. During an interview, HCA #109 indicated that was the usual position for the resident, even during food and fluid intake.

During several meal and nourishment service observations, Inspector also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During an interview, the Administrator indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe and upright position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; residents #003, #006, #010 and #011's current written plans of care and MDS assessments; interviews with PSWs, HCAs, RPNs, RNs and the Administrator.
[672]

WRITTEN NOTIFICATION: Nutrition and Hydration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (2) (b)

The licensee failed to ensure that residents who required assistance with eating and drinking were served meals until someone was available to provide the required assistance.

Rationale and Summary:

On an identified date, at 1245 hours, resident #001 was observed to have their lunch meal served to them in their room via tray service, but the resident was not observed to be in their bedroom. Upon questioning, PSW #101 indicated they did not have time at that moment to go and locate the resident, only to deliver the meal, but when a staff member was available to assist the resident with their meal, they would go and locate the resident at that time. Just after 1300 hours, PSW #101 went to locate resident #001 and was able to provide them with the required set up and/or assistance at that time. Although the meal had been plated for more than 15 minutes, no staff were observed to offer to reheat any of the food or fluid items.

On an identified date, at 1255 hours, residents #004 and #005 were observed to have their lunch meals plated and sitting on a tray in a rack outside of the nursing station, prior to any staff members being available to provide the required assistance for either of the residents to consume their meals. Upon

questioning, HCA #102 indicated the meals were waiting for a staff member to be available to provide the required assistance, as all staff were currently busy assisting other residents with their meals. Staff were not observed to return to assist residents #004 and #005 with their meals for more than 20 minutes, and no offer to reheat either of the meals were noted.

During separate interviews, the Administrator indicated the expectation in the home was for meals to not be served to any resident who required assistance until a staff member was available to provide the assistance required. RN #107 indicated serving meals to residents prior to having a staff member available could have negative effects on the residents, such as decreased intake due to improper/cool temperatures of the food/fluid items or possible incidents of choking/aspiration. This failure posed a risk of poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

By not ensuring residents were not served their meals until a staff member was available to provide the required assistance, residents were placed at risk of having poor intake of both food and fluid items.

Sources: Observations conducted; interviews with PSW #101, HCA #102, RN #107 and the Administrator. [672]

WRITTEN NOTIFICATION: Personal Items and Personal Aids

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 41 (1) (a)

The licensee failed to ensure that personal items were labelled, as required.

Rationale and Summary:

While conducting observations throughout the inspection, Inspector observed multiple personal items in shared resident bathrooms, bedrooms, spa and shower rooms, such as used rolls of deodorant, hair combs and hairbrushes, denture cups, toothbrushes, lotions and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs, the IPAC Lead and the Administrator verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs, the IPAC Lead and the Administrator.
[672]

WRITTEN NOTIFICATION: Hazardous Substances

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 97

The licensee failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Rationale and Summary:

During observations made throughout the inspection, Inspector noted there were tub rooms and utility rooms which had doors that would only close and lock if the staff purposefully pulled the doors closed. Due to this, staff would often enter the rooms and not pull the doors tightly closed behind them after finishing in the room therefore the rooms were accessible to residents. There were also communal resident bathrooms in the hallways which were accessible to residents at all times. Stored within these rooms were multiple different hazardous substances and supplies such as 500ml bottles of antibacterial hand cleanser, bottles of Odour Eliminator, 946ml bottles of peroxide disinfectants, bottles of glass cleaner and bottles of Accel Intervention disinfectant. During separate interviews, PSWs, RPNs, housekeeping staff and the IPAC Lead indicated some of the products were routinely stored in the resident bathrooms, such as bottles of Odour Eliminator, 946ml bottles of peroxide disinfectants, bottles of glass cleaner and bottles of Accel Intervention disinfectant. The PSWs, RPNs, housekeeping staff, IPAC Lead and the Administrator indicated the expectation in the home was for staff to always ensure the doors to tub, shower and utility rooms were always pulled closed tightly, so that residents could not freely access these areas.

By not ensuring the hazardous substances were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted, interviews with PSWs, RPNs, housekeeping staff, the IPAC Lead and the Administrator.
[672]

WRITTEN NOTIFICATION: Medication Administration

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 139 1.

The licensee failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies, which was kept secured and locked.

Rationale and Summary:

Inspector observed the door to the tub room across from room #30 had been left open, with no staff in the area and several residents wandering in the hallway. Within the room was a supply cart with a plastic basket on top which stored medicated treatment creams for multiple residents in the home. Following the observation, Inspector closed the tub room door and reported to RN #107 that the medicated treatment creams had been left in the tub room, so they could be safely secured in the appropriate area.

During separate interviews, RNs #106 and #107 and the Administrator verified the expectation in the home was for medicated treatment creams to be kept secured and locked at all times in the appropriate administration cart at the nursing station when not being utilized by staff.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted and interviews with RNs #106, #107 and the Administrator.
[672]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infections in residents #007, #008, #012, #013 and #014 were monitored and recorded.

Rationale and Summary:

Inspector #672 reviewed the internal infection line list for a specified month and noted that residents #007, #008, #012, #013 and #014 had each been diagnosed with an infection during the month. Review of resident #007, #008, #012, #013 and #014's electronic health care records indicated they were each diagnosed with an infection and an order from the physician was received for a specified treatment. Inspector then reviewed resident #007, #008, #012, #013 and #014's progress notes and noted there was not documentation from every shift to indicate the presence of symptoms or infection were monitored and recorded while each resident received the specified treatment.

During separate interviews, RPN #112, RNs #106, #107 and the IPAC Lead indicated the expectation in the home was for registered staff to assess, monitor and document a resident's symptoms while they were ill with an infection and receiving antibiotic therapy on the first day the therapy was initiated, at some point during the antibiotic therapy to indicate if the treatment was improving the resident's symptoms and then on the final day of the antibiotic therapy.

By failing to ensure that symptoms indicating the presence of infections in residents were monitored and recorded on every shift, residents were placed at risk of having the symptoms from their infections worsening and not being noted by staff.

Sources: Internal infection line list for a specified month; residents #007, #008, #012, #013 and #014's progress notes and vital sign assessments from the specified month; interviews with RPN #112, RNs #106, #107 and the IPAC Lead.
[672]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (3) (a)

The licensee failed to ensure that responsive behaviour interventions were implemented by PSWs #104 and #115, when providing personal care for resident #009.

According to O. Reg. 246/22 s. 58 (1), the licensee was required to ensure written strategies, including techniques and interventions to prevent, minimize or respond to responsive behaviours were developed to meet the needs of the residents.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to an allegation of staff to resident abuse between PSW #115 and resident #009. The CIR indicated that resident #009 presented with an identified responsive behaviour, but required assistance with personal care, therefore PSWs #104 and #115 provided care to the resident. While attempting to provide the care, resident #009's identified responsive behaviour continued, which led to PSW #115 abusing the resident.

Review of resident #009's written plan of care indicated the resident could present with an identified responsive behaviour at specified times, therefore staff were to implement an identified intervention when attempting to provide personal care. If the resident continued to present with the identified responsive behaviour, staff were expected to implement another identified intervention.

During separate interviews, PSW#115, RCC #113 and the Administrator/DOC indicated that when the resident presented with specified responsive behaviours, staff should implement identified interventions.

By not ensuring responsive behaviour interventions were implemented by PSWs #104 and #115, when providing personal care for resident #009, the resident was placed at risk for injury.

Sources: Specified Critical Incident Report; resident #009's health records; licensee's internal investigation notes and PSW# 115's employee file; interviews with PSWs #104 and #115, RCC #113 and the Administrator/DOC.
(571)

WRITTEN NOTIFICATION: Prevention of Resident Abuse

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure an allegation of physical abuse toward resident #009 was reported immediately to the Director.

Rationale and Summary

On a specified date, PSW #104 reported to RN #116 an allegation of abuse by PSW #115 toward resident #009. The Director was not notified until the following day. During an interview, RCC #113 acknowledged that the home failed to inform the Director immediately.

By not ensuring the allegation of abuse toward resident #009 was reported immediately to the Director, residents were potentially placed at risk of being abused by staff members.

Sources: **Specified Critical Incident Report**; interview with RCC #113.
(571)

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure their internal policy to promote zero tolerance of resident abuse and neglect was complied with.

Rationale and Summary

On a specified date, PSW #104 reported to RN #116 an allegation of abuse by PSW #115 toward resident #009. The Director was not notified until the following day. Review of the licensee's internal policy related to the prevention of resident abuse indicated that any person who had reasonable grounds to suspect the abuse of a resident was obligated by law to immediately report the suspicion and the information upon which the suspicion was based to the Director, Administrator or manager on call.

During separate interviews, RCC #113 indicated they did not know why PSW #104 failed to immediately report the allegation of abuse to the charge nurse, as per the licensee's internal policy. PSW #104 indicated that they reported the allegation of abuse to RN #116 approximately one to one and a half hours after the incident. PSW #104 stated that they now know that they should report allegations of resident abuse immediately to the charge nurse.

By not ensuring the internal policy to promote zero tolerance of resident abuse and neglect was complied with, residents were placed at risk of being abused by staff members.

Sources: **Specified Critical Incident Report**; internal policy related to the zero tolerance of abuse and neglect of residents and interviews with RCC #113 and PSW #104.
[571]

COMPLIANCE ORDER CO #001 Infection Prevention and Control

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22 s. 102 (8).

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management and IPAC team to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing, usage and supply of PPE items to ensure PPE is present (as necessary) and being utilized, donned and doffed as required, for any resident who requires precautions to be implemented. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Educate front line staff members on the PPE items required to be present in the PPE stations for residents who require contact and/or droplet precautions to be implemented. Education is to include the required PPE items, who is responsible for replenishing the items when they are getting low and where/how to locate each of the items in order to restock the PPE stations. Keep a documented record of the education completed, along with the sign in sheets for the staff attending the education and make available for Inspectors, upon request.

Grounds
The licensee has failed to ensure that all staff participated in the infection prevention and control program.

Rationale and Summary:

During observations conducted during the inspection, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services or following the provision of resident care. This included observations of staff removing dirty dishes and/or flushing toilets in resident rooms and not completing hand hygiene prior to assisting the next resident with their afternoon nourishment.

- Staff were observed entering and/or exiting resident rooms while donning and/or doffing PPE items in an incorrect manner or sequence.

- Staff were observed to be walking in the hallways while donned in PPE items such as gowns and gloves.

- Staff were observed serving food items from the nourishment carts by picking the snack food items up in their bare hands in order to rest it on a napkin and serve it to a resident.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- Soiled face and peri cloths were observed to be sitting on the countertops, in the sinks and on the floor of two communal bathrooms on an identified date.

- PPE stations outside of resident room(s) who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Staff members were observed to be in resident bedrooms where contact/droplet precautions were required to be implemented without wearing all of the required PPE items.

- Staff were observed using equipment for multiple residents without cleaning or disinfecting the equipment between usage, such as mechanical and sit to stand lifts.

- Staff were observed walking down the hallways carrying soiled incontinent products in their hands.

- There were several shared resident spaces such as bathrooms and/or shower rooms which had unlabeled personal items in place, such as used hairbrushes and rolls of deodorant.

- Several residents in the home who required contact/droplet precautions to be implemented did not have the required signage posted outside the resident's environment and/or at the resident's bedside.

- Upon entering the home, staff were required to complete an "Active Screening Log", which was to be verified as passed and completed by a manager. Upon review of the screening logs, there were multiple entries over several dates which did not include verification signatures.

- Several residents had signage posted outside their environment which stated they required contact/droplet precautions to be implemented, along with PPE stations, but staff indicated the residents no longer required precautions to be implemented.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, housekeeping and dietary staff, IPAC Lead and the Administrator.
[672]

This order must be complied with by December 7, 2022

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.