

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 28, 2023	
Inspection Number: 2023-1172-0003	
Inspection Type: Follow up	
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 Holly Wilson (741755)	Inspector Digital Signature
Additional Inspector(s) Rodolfo Ramon (704757)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 25, 26, 2023

The following intake(s) were inspected:

- follow-up related to O. Reg 246/22 - s.97
- follow-up related to O. Reg 246/22 - s. 139 (1)
- follow-up related to FLTCA, 2021 - s. 28 (1) 2.

Previously Issued Compliance Order(s)

- The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2023-1172-0002 related to O. Reg. 246/22, s. 97 related to hazardous materials inspected by Holly Wilson (741755)

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Order #003 from Inspection #2023-1172-0002 related to O. Reg. 246/22, s. 139
1. related to obtaining and keeping drugs inspected by Rodolfo Ramon (704757)

Order #001 from Inspection #2023-1172-0002 related to FLTCA, 2021, s. 28 (1)
2. related to immediate reporting of abuse by Holly Wilson (741755)

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

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

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)

O. Reg. 246/22, s. 97

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

Rationale and Summary:

While conducting a tour of the home, Inspector 741755 observed that a resident's room had storage of Purell Hand Sanitizer and Purell blue Hand soap in opened and unopened boxes.

The Executive Director/Director of Care (ED/DOC) confirmed the expectation of the

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home was to keep hazardous substances locked and inaccessible to residents.

Failure to secure hazardous substances presented a low risk of residents access to the hazardous substances. When the ED/DOC was made aware of the observation, the hazardous substances were immediately removed from the resident's room and placed in a locked location.

Subsequent observations throughout the inspection revealed no further concerns with residents' access to hazardous substances.

Sources: Observations, Interview with the ED/DOC.

[741755]

Date Remedy Implemented: July 25, 2023



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

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