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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Public Report

Report Issue Date: February 19, 2025

Inspection Number: 2025-1172-0001

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Streamway Villa, Cobourg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5, 7, 14, 2025.
The inspection occurred offsite on the following date(s): February 6, 13, 2025.

The following intake(s) were inspected:
- An intake related to a disease outbreak.
- An intake related to the fall of a resident resulting in injury and a significant change in health status.

The following intake(s) were completed in this inspection:
- An intake related to the fall of a resident resulting in injury.
- An intake related to the fall of a resident resulting in injury.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital

The licensee shall ensure that a resident, at risk of altered skin integrity, receives a skin assessment upon return from hospital.

A Critical Incident Report (CIR) was submitted to the Director for a resident fall that resulted in injury and a significant change in health status.

Review of a resident's progress notes confirmed that the resident returned from hospital on a specific date. Review of a resident's skin assessments confirmed that a skin assessment was not conducted upon their return from hospital.

A Registered Nurse (RN) confirmed that a resident did not have a skin assessment conducted upon return from hospital and should have.

Sources: A CIR, a resident's clinical health records, the home's policies/procedures, and an interview with staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9)

Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that symptoms indicating infection for two residents were recorded on every shift.

The Director of Care (DOC) confirmed that Registered Staff were to monitor residents for symptoms of infection on every shift and document the monitoring in the resident's progress notes.

Review of a resident's progress notes confirmed that they were not monitored, and their symptoms recorded on every shift.

Review of another resident's progress notes confirmed that they were not monitored, and their symptoms recorded on every shift.

Sources: A CIR, the home's Outbreak records, two residents' clinical health records, the home's policies/procedures, and an interview with staff.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is

immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed for an outbreak of a disease of public health significance or communicable disease.

A CIR was submitted to the Director for a disease outbreak.

Review of the Local Public Health Unit's (LPHU) Outbreak Record confirmed that the disease outbreak was declared on a specific date.

Review of the CIR confirmed that the disease outbreak was not immediately reported to the Director.

The DOC confirmed that nursing staff did report immediately inform the Director of the disease outbreak and should have.

Sources: A CIR, PHU Outbreak Record, the home's policies/procedures, and an interview with staff.