Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: February 21, 2023	
Inspection Number: 2023-1187-0002	
Inspection Type: Other – Follow up inspection	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Burnbrae Gardens Long Term Care Residence, Campbellford	
Lead Inspector Sharon Connell (741721)	**Inspector Digital Signature**
Additional Inspector(s) Chantal Lafreniere (194)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 23 to 27, 2023

The following intake(s) were inspected:
- A follow-up intake from Inspection #2022_1187_0001, Compliance Order (CO) #001, LTCHA, 2007, s. 19 (1) related to Duty to Protect with a Compliance Due Date (CDD) of September 2, 2022.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022_1187_0001, related to LTCHA, 2007, s. 19 (1) Duty to Protect inspected by Chantal Lafreniere [194].

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control Program Standard 9.1 Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: (d) Proper use of PPE, including appropriate selection, application, removal, and disposal. A personal support worker (PSW) did not apply appropriate personal protective equipment (PPE) when providing care to a resident under additional precautions.

Rationale and Summary:

A PSW was observed assisting a resident who was under additional precautions, without applying PPE during care. The PSW stated that the resident did not have any additional precaution requirements, then returned to Inspector #194 stating that they should have applied PPE during care. The resident's plan of care and PSW work sheet, indicated that PPE was required when providing care to the resident.

Failing to ensure that appropriate PPE are worn during care of residents requiring additional precautions increases the risk of spreading infections in the home.

Source: Resident plan of care, PSW worksheet and interview with staff (PSW and RAI Coordinator) [194]

WRITTEN NOTIFICATION: DOORS IN HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary:

On two separate observations the electrical room door was left unlocked. The room is located off the hallway leading to the dining room in the home. There was no one in the electrical room at the time the door was observed to be unlocked.

The Environmental Service Manager (ESM) stated that the electrical room door was left unlocked when the maintenance staff was in the building. The ESM confirmed that the electrical room door should be locked at all times. A housekeeper stated that the electrical room door in the home was generally locked, unless the maintenance staff was working. When the maintenance staff was working, their office was located in the electrical room and the door was left unlocked.

Failing to ensure that doors leading to non-residential areas are kept locked when they are not being supervised by staff, places residents at risk of being trapped in an unsupervised area.

Sources: Observation and interview with staff. (ESM and Housekeeper) [194]

WRITTEN NOTIFICATION: TRAINING

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee failed to ensure that agency staff received training in the areas of infection prevention and control, prior to performing their responsibilities.

Rationale and Summary:

Surge e-Learning records indicated that several agency Registered Practical Nurses (RPNs), had no record of Infection Prevention and Control (IPAC) training since their date of hire.

An agency RPN confirmed that they had not received IPAC training since being hired.

The DOC confirmed that there was no formal orientation process for training related to agency staff at the home.

Failure to ensure that all staff received training in the areas of infection prevention and control, placed residents at risk for the spread of disease.

Sources: Interviews with an agency RPN and DOC, Surge e-Learning records for three agency workers. [741721] [194]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to carry out every operational or policy directive that applies to the long-term care home.

Rationale and Summary:

A support worker was observed entering the home six minutes after placing the drops from the rapid antigen testing solution onto the testing device.

The support worker acknowledged awareness of the 15-minute waiting period to read rapid antigen test results, however read the test prior to the 15 minutes and entered the home.

COVID-19 Long-Term Care Home guidance document, December 2022, Section 12, directs home's to ensure that support workers entering the home must receive and demonstrate a negative test result from an antigen test taken at the long-term care home on that day.

Manufacturer's instructions for the rapid antigen test kit directs users to wait 15 minutes after putting the drops into the sample well or the results may not be accurate.

Failing to ensure support worker compliance with the rapid antigen testing procedure, prior to entry into the home, placed residents at risk for exposure to COVID-19.

Sources: Observation and interview of support worker, COVID-19 Long-Term Care Home guidance document, December 2022, Section 12, manufacturer’s instructions for the COVID-19 rapid antigen test. [741721]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of contact surfaces using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:

A housekeeper was observed repeatedly dipping a soiled microfibre cloth back into a bucket of disinfectant, and wringing it out, as they performed high touch surface cleaning.

The Environmental Services Manager (ESM) confirmed that training for housekeeping staff included not placing soiled cleaning cloths back into the disinfectant, they were to use a two-bucket system.

The home's protocol outlined steps for cleaning using a two-bucket system. Fill one yellow bucket half full with Peroxide Multi Surface Disinfectant and Cleaner and use the other red bucket for dirty cloths.

The provincial environmental cleaning best practice document recommends frequently changing the disinfectant solution and wiping cloths, and not dipping a soiled cloth into the disinfectant solution (i.e., no “double-dipping”) to help prevent contamination of the disinfectant solution.

Failing to ensure that cleaning and disinfection of contact surfaces using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, placed residents at risk for spread of disease.

Sources: Observation, interviews with ESM and housekeeper, the home’s protocol for cleaning high touch surfaces, provincial environmental cleaning best practice document. [741721]

WRITTEN NOTIFICATION: EXEMPTIONS, TRAINING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 262 (2)

The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services. Specifically with respect to persons who, (b) will only provide occasional maintenance or repair services to the home.

FLTCA, 2021, s. 82 (2) 9.
(2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in: 9. infection prevention and control.

Rationale and Summary:

Hand hygiene and equipment cleaning was not observed when a contracted service worker exited a resident’s room, who was identified as requiring additional precautions.

The contracted service worker confirmed that they had not spoken to any staff prior to entering the resident's room and had no knowledge of the additional precautions.

An Registered Nurse (RN) confirmed that they had not approached the contracted service worker to provide infection prevention and control (IPAC) instructions prior to entry into the resident’s room who was in additional precautions and that there was no formal process to educate occasional maintenance or repair service workers. They stated that service workers not receiving IPAC education would be a concern when entering the room of a resident who required additional precautions.

The IPAC lead confirmed that there was no process currently, for providing IPAC education to contracted service workers or other general visitors.

Failing to ensure that contracted service workers entering the home were provided IPAC education, put the service worker and resident at risk, when a situation occurred requiring additional precautions to be followed.

Sources: Observation of service worker, interviews with service worker, RN and IPAC Lead. [741721]