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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: January 8, 2024
Inspection Number: 2024-1177-0001
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: Rosebridge Manor, Jasper

Lead Inspector	**Inspector Digital Signature**
Maryse Lapensee (000727)	Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2024.01.09 09:45:56 -05'00'

Additional Inspector(s)
Training Specialist Amber Lam (541) was present on site as an observer during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3, 4, 2024

The following intake(s) were inspected:

- Intake: #00099052 / CI #2671-000009-23 related to a fall with injury

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

Infection Prevention and Control
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard issued by the Director was followed. Specifically related to additional precautions including point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary
On January 3, 2024, Inspector #000727 observed a yellow apron of Personal Protective Equipment (PPE) on the door of a room on a specific wing. There was no precaution signage posted on the door.

A staff member and IPAC Lead confirmed that a resident in the room was on contact

precaution.
On January 4, 2024, Inspector #000727 observed a contact precaution sign on the door of a room on the specific wing.

Sources: Observations, interview with a staff member and IPAC Lead

Date Remedy Implemented: January 4, 2024
[000727]