



**Inspection Report
under the Long-Term
Care Homes Act, 2007**

**Rapport d'inspection
prévue le Loi de 2007
les foyers de soins de
longue durée**

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
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<input type="checkbox"/> Licensee Copy/Copie du Titulaire <input checked="" type="checkbox"/> Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection February 11, 2011	Inspection No/ d'inspection 2011_128_907_20Jan090653	Type of Inspection/Genre d'inspection L-00022 -Complaint

Licensee/Titulaire
Omni Healthcare (Country Terrace) Limited Partnership on behalf of Omni Healthcare (CT) GPCO Ltd. as
General Partner, 161 Bay Street, Suite 2430, TD Canada Trust Tower, Toronto, ON M5J 2S1

Long-Term Care Home/Foyer de soins de longue durée
Country Terrace, 10072 Oxbow Drive, R. R.#3, Komoka, ON N0L 1R0

Name of Inspector(s)/Nom de l'inspecteur(s)
Ruth Hildebrand (ID #128)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to food quality.

During the course of the inspection, the inspector spoke with the Administrator, Nutrition Manager, Critical Care Coordinator, 2 Registered Nurses, 2 Registered Practical Nurses, 4 personal support workers, 1 cook, 1 dietary aide and 11 residents.

During the course of the inspection, the inspector observed morning snack in the Evergreen wing and lunch in the main dining room. Food temperatures were taken at the lunch meal and residents were interviewed related to the quality of the food in the home. Food Committee minutes were reviewed for the last 6 months. Resident records were reviewed for two residents.

Throughout the course of the inspection issues that were unrelated to the complaint were identified as non-compliant.

The following Inspection Protocols were used in part or in whole during this inspection:

- Food Quality
- Nutrition and Hydration

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.11(2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

Findings:

Three residents on thickened fluid diets were provided food that was not safe. These residents were provided with jello for dessert, at the lunch meal, on February 11, 2011. The Nutrition Manager acknowledged that jello becomes a thin fluid in the mouth.

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with food and fluids that are safe, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s. 6 (1)(c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

A resident was assessed on February 1, 2011, by the Registered Dietitian, as requiring nectar thick fluids. A personal support worker, Nutrition Manager and Administrator acknowledged that they were not aware that this resident was to be on thickened fluids, despite the diet list indicating same. The resident was provided thin fluids at a.m. snack on February 11, 2011 and coughed while being provided the thin fluids. Inconsistencies related to the diet were noted throughout the plan of care.

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written plan of care for each resident that sets out clear directions is available to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Findings:

A resident was provided fluids while in an unsafe position, at a.m. snack, February 11, 2011. This resident coughed while being provided fluids by a Personal Support Worker. The Critical Care Coordinator acknowledged that resident was in an unsafe position.

Additional Required Actions

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are assisted with eating in a safe feeding position, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:	February 14, 2011 <i>Ruth Hildebrand</i> Date of Report: (if different from date(s) of inspection).