Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2015	2015_264609_0019	003925-15 & 003776-15	Complaint

Licensee/Titulaire de permis

OMNI HEALTHCARE (COUNTRY TERRACE) LIMITED PARTNERS
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 ou des inspecteurs

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 20, 2015

During the course of the inspection, the inspector(s) spoke with one Administrator, one Director of Care, two Registered Nurses, two Registered Practical Nurses and four Personal Support Workers.

The inspector also reviewed clinical records, the home's policies and procedures, staff schedules, staff education logs, incident reports, and correspondence between the home and the Community Care Access Center.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to a resident.

A) An identified resident was placed on monitoring in order to mitigate responsive behaviour towards other residents.

Review of the clinical records indicated that on five separate occasions the identified resident had altercations with at least two cognitively impaired residents despite the dedicated monitoring by staff.

On an identified date the staff responsible for monitoring responded to an alarm bell of another resident resulting in the identified resident being unattended and unsupervised. While the staff member was attending to a different resident, the identified resident had another altercation with a resident.

Review of the plan of care did not outline the specific interventions monitoring staff were to utilize in order to minimize the risk of altercations with other residents.

The Administrator confirmed that the plan of care did not clearly or explicitly outline the actions monitoring staff were to use to mitigate the resident's responsive behaviours and the expectation of the home for the identified resident is it should have been clearly identified.

B) Interviews with two Registered Staff and four Personal Support Workers indicated that when the identified resident is in bed a specific intervention was to be in place.

Review of the plan of care did not indicate the identified intervention. Interview with Registered Staff confirmed that it should have been outlined in the plan of care. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 146. When licensee shall discharge

Specifically failed to comply with the following:

s. 146. (4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days; O. Reg. 79/10, s. 146 (4).
(b) the resident is on a psychiatric absence that exceeds 60 days; O. Reg. 79/10, s. 146 (4).
(c) the total length of the resident's vacation absences during the calendar year exceeds 21 days; or O. Reg. 79/10, s. 146 (4).
(d) the long-term care home is being closed. O. Reg. 79/10, s. 146 (4).

Findings/Faits saillants :

1. Interview with the Administrator confirmed that on a specified date, an identified resident was sent to hospital and admitted for an acute evaluation and was discharged from the home on the same day as the hospital admission.

Review of the letter of discharge from the home which was sent to the Regional Client Services Manager at the South West Community Care Access Center sent the same day as the identified resident was admitted to hospital, indicated that the home will not maintain the resident's bed during the admission to hospital. The letter outlined that the home will not consider alternatives to discharge despite the ongoing acute assessment of the identified resident.

The Administrator confirmed that on the day of admission to hospital the identified resident was officially discharged related to the home's inability to ensure the safety of other residents from the inappropriate behaviour of the identified resident. [s. 146. (4) (b)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 9th day of April, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.