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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2015	2015_254610_0049	031515-15	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership
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

NATALIE MORONEY (610), INA REYNOLDS (524), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 23, 24, 25, 26 ,27, 30, December 1, 2, 3, and 4, 2015

The following Critical Incidents were conducted and concurrently during this inspection:
 # 032025-15/ CI 0907000021-15 # 033304-15/ CI 0907000022-15 and 0907000023-15 #028408-15/ CI 0907000017-15 and # 006124-15/ CI 0907000004-15.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, Ontario Provincial Police Officer, 10 Personal Support Workers, 2 Registered Nurses, 3 Registered Practical Nurses, one Life Enrichment Coordinator, one Clinical Coordinator, one Resident Care Coordinator, one Maintenance Manager, one Maintenance Assistant, one Housekeeper, one Food and Nutrition Manager, two Cooks, one Resident Assessment Instrument Nurse, one Physiotherapist, Families, Resident Council Representative and Resident's.

The inspector(s) also conducted a tour of all resident home areas and common areas; observed residents and care provided to them; observed meal service, medication passes; medication storage area; reviewed health care records and plans of care for identified residents;reviewed policy and procedures of the home, minutes from the meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **9 VPC(s)**
- **1 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident observations on November 23, 24, and 25, 2015, during stage 1 of the Resident Quality Inspection revealed 24 of 40 or 60% of residents had one or more bed rail in use.

Record review of the resident clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Further record review of the Country Terrace "Bed Entrapment Audit" revealed it was completed by an independent company. All bed systems were evaluated, however the staff confirmed the home had not completed an assessment for all residents using bed rails. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity.

The Resident Quality Inspection process revealed that four residents had concerns that they were not treated with respect and dignity.

The Administrator confirmed that it is the homes expectation that residents rights to be treated with respect and courtesy and that residents were reporting disrespectful behaviour by staff.

The home had failed to ensure that the residents were fully respected and promoted regarding the resident's right to be treated with courtesy and respect. [s. 3. (1) 1.]

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 fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #3: 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A review of the resident plan of care showed that a resident had a therapeutic recreation plan that staff were to assist with.

An interview with staff revealed it was not clear who was to provide the therapy and it was not being provided by anyone.

The licensee had failed to ensure that the written plan of care set out clear directions as to who was to apply the therapeutic recreation plan [s. 6. (1) (c)]

2. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A record review of resident #024 plan of care revealed staff were to complete a treatment during the day and in the evening.

During a resident observation it showed that the resident day treatment plan was not

completed.

An interview with staff confirmed it was the home's expectation that the staff will follow the directions as outlined in the plan of care.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The care plan included information regarding how the resident was to be repositioned using a therapeutic device.

On November 27, 2015, staff confirmed that they do not always use the therapeutic device.

The Administrator confirmed that staff should have provided the device as outlined in the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

4. The Licensee has failed to ensure that the provision of bath care set out in the plan of care was documented.

A review of the bathing schedule revealed resident #023 was scheduled to be bathed bi-weekly.

A record review of the Personal Support Worker Observational Flow Sheet revealed there was no documented bath for a ten day period.

The staff confirmed the home failed to document baths at a minimum of twice per week for resident #023. [s. 6. (9) 1.]

5. The Licensee has failed to ensure that the provision of bath care set out in the plan of care was documented.

A review of resident # 045 flow sheet revealed that the bathing activity had not been documented and only three scheduled bathing choices were documented.

The Administrator confirmed that resident # 045 should have been offered bi-weekly bathing and confirmed that the bathing should be documented. [s. 6. (9) 1.]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident and is provided to the resident as specified in the plan and documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of the home's "Resident Falls" policy #CS-12.1 dated January 2011, directed that "All staff must be aware that if a resident falls, the charge nurse is to be notified immediately.

The resident is to be made comfortable, but not moved until he/she has been seen by the

charge nurse." In addition, the charge nurse was responsible to assess the resident before moving the resident for pain, dislocations, fractures and level of consciousness. When the nursing assessment indicated that it was safe to move the resident, the resident would be returned to bed for a more thorough examination.

Resident #017 had a fall and documentation showed that staff did not follow the falls policy.

The Director of Care stated that the home's expectation is that when a resident has fallen, the Resident Falls policy was to be complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of policy CS-9.2 Maintenance of the Clinical Record, January 2011, revealed it was the homes expectation that all entries in the clinical record shall be made in sufficient detail, such that future reference can be made and all pages in the clinical record would clearly state the resident's full name.

A resident was to be on documented security checks. The date and the resident name was missing from the document as well as approximately 3.5 hours of security checks.

An interview with the RAI – Coordinator confirmed the date was incomplete and the name of the resident was missing.

An interview with the Director of Care confirmed the homes expectation was that the documentation should have sufficient detail, such that future reference can be made and that all pages in the clinical record would clearly state the resident's full name. [s. 8. (1) (b)]

3. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A record review of Medication Incident Reports revealed that there were four medication incidents and all four incident reports were incomplete.

On December 02, 2015, an interview with the Director of Care confirmed the

documentation of the medication incidents were not completed and it was the homes expectation that all documentation would be completed.

The home did not follow their policy to ensure all entries in the clinical record contained sufficient detail. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

During the home tour on November 23, 2015, Inspector # 521 was able to open two Chapel windows greater than 15 centimeters.

On November 25, 2015, Inspector # 521 was able to open one window in the east activity room greater than 15 centimeters that did not have a screen.

The east and west wing activity room windows that had opened up to the outside were missing five out of eight window screens.

The Clinical Care Coordinator and the Maintenance Manager confirmed that the windows should be open less than 15 centimeters and the Administrator confirmed that the windows should have screens.

The licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters. [s. 16.]

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 ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee had failed to ensure that every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On December 2, 2015, during an observation of the tub chair on the west wing, Inspector #610 observed that the belt clip was broken on one side of the latch.

A staff confirmed on December 2, 2015 a bath was completed using that tub chair.

Inspector # 610 showed the Administrator the broken clip on the tub chair.

The Administrator confirmed that the belt for the tub chair was broken and was not safe for use.

The licensee had failed to ensure that the staff use of all equipment was used according to the manufacturer's instruction. [s. 23.]

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 that every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

A review of resident's # 045 plan for oral health showed that the resident was to receive oral health care daily with assistance.

The resident confirmed that oral health care was completed once a day during the evening.

The Administrator confirmed that resident # 045 should be receiving oral care after breakfast, lunch, and dinner.

The licensee had failed to ensure that resident # 045 receives oral mouth care in the morning and evening as required by the regulation. [s. 34. (1) (a)]

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 ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A record review on December 3, 2015, of the med e-Care wound tracker assessment indicated resident # 024 had wound assessments that were overdue.

A review of the paper assessment required on the Treatment Administration Record (TAR) revealed resident #024 was to receive a weekly wound assessment.

The review revealed there was no documentation to indicate the assessment had been completed.

The licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that all food and fluids are prepared, and served using methods to prevent adulteration, contamination and food borne illness.

An observation revealed an open cup of apple sauce on each of the medication carts and that on one medication cart a resident had accessed the apple sauce.

The licensee did not use methods to prevent adulteration or contamination by leaving the applesauce uncovered when not in use. [s. 72. (3)]

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 all food and fluids in the food production system are prepared, stored, and served using methods to, prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

An interview with resident #026 confirmed that the resident was self administrating a medication.

A review of Policy 5-5 Self – Administering of Medications page 2/4 states the nurse has access to the resident's stored medication, monitoring and documentation.

An interview with the Nurse explained the home had no role in the management, administration or access to the stored medication.

A review of the resident's health care record revealed that the resident did not have a current order by the prescriber to self-administer.

An interview with the Administrator on December 01, 2015, confirmed the home was not following their policy on Self-Administration and there was no documented approval for self-administration of this drug. [s. 131. (5)]

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 that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that procedures were developed to address incidents of lingering offensive odours.

During an observation there was a lingering offensive odour in the residents room.

The Plan of Care further identified the room to be clean and to have a clean odour. Interventions included a daily room audit by housekeeping to ensure standards were being met.

An interview with housekeeping staff revealed they had not always been successful in attempts to address this odour as staff were not following the procedure as outlined. This was confirmed by the Administrator and the Environmental Services Supervisor. [s. 87. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee had failed to inform the Director no later than one business day after the occurrence of the incident of: 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Record review of two incidents revealed that two residents had a change in condition related to falls.

Interview with the Administrator on December 3, 2015, confirmed the home had notified the Director later than one business day after the residents had a fall that caused an injury that resulted in a significant change in the resident's health condition and for which the residents were taken to hospital. [s. 107. (3) 4.]

Issued on this 15th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MORONEY (610), INA REYNOLDS (524), REBECCA DEWITTE (521)
Inspection No. / No de l'inspection :	2015_254610_0049
Log No. / Registre no:	031515-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 23, 2015
Licensee / Titulaire de permis :	Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership 161 Bay Street, Suite 2430, TD Canada Trust Tower, TORONTO, ON, M5J-2S1
LTC Home / Foyer de SLD :	COUNTRY TERRACE 10072 Oxbow Drive, R.R. #3, Komoka, ON, N0L-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Dann

To Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The plan must include, but is not limited to:
1. When the home's policy will be reviewed and updated regarding the resident's assessment for bed rails, and by whom.
2. What assessment tool will be used to complete the resident assessments for those residents using bed rails to minimize risk to the resident
3. When will all assessments be completed
4. Who will be completing the assessments
5. Who will educate the staff on how to do the assessments

Please submit a plan, in writing, to Natalie Moroney, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2 by email to natalie.moroney@ontatio.ca by January 18, 2015.

Grounds / Motifs :

1. The licensee had failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident observations on November 23, 24 and 25, 2015 during stage 1 of the Resident Quality Inspection revealed 24 of 40 or 60% of residents had one or more bed rail in use.

Record review of the resident clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Record review of the Country Terrace "Bed Entrapment Audit" revealed it was completed by an independent company Joerns in May 2015. All bed systems were evaluated, however the Administrator, Resident Assessment Instrument (RAI) Coordinator and Registered Nurse confirmed the home had not completed a bed assessment for all residents using bed rails.

The scope of this incident is noted to be a pattern as 60 percent of the resident observed had one or more bed rails in use. The severity of risk was minimal harm/potential for actual harm. There was previous compliance history for O.Reg.79/10, s.15 (1) related to possible bed entrapment on April 12, 2013, and was issued as an order # 2013_206115_0018. The order was cleared and put back in to compliance on August 21, 2013.
(524)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

Service Area Office /
Bureau régional de services : London Service Area Office