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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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 21, 2016	2016_254610_0008	001546-16	Complaint

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)

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 10, 11, 14, 2016

This complaint inspection was related to Dignity, Choice and Privacy, and Complaints and Reporting.
This finding is further evidence to support the order issued on inspection 2016_254610_0007 Log #034192-15 on November 3, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, one RAI-Coordinator, one RAI Coordinator Nurse, Administration Assistant, Clinical Coordinator, Acting Director of Care, one Behavioural Nurse, One Behavioural Personal Support Worker, one Personal Support Worker, two Registered Practical Nurses, Infection Control Nurse, and the Admission Coordinator.

During the course of the inspection the inspector completed resident observations, and interviews, reviewed policy and procedures and relevant documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

A written letter had been provided to the home that showed concerned regarding resident care.

•A Record review of the complaint log failed to identify the written complaint.

Another written report showed the family had not received a response within the ten business days to previous written complaints.

•A record review for resident # 004 showed alleged sexual abuse. This complaint failed to have a complaint log or an internal risk report.

The home's policy number AM-6.1 titled Complaints Procedure stated
Any complaint given to a staff member, whether verbally or written, shall be directed or communicated immediately to the Administrator of the home.

Interview with the Administrator # 103 confirmed that she was aware of the written complaint and that the complaint failed to be a part of the complaint log and that there was no response provided. The Administrator # 103 also confirmed that the complaint should have been responded to within ten business days and that the home should have had a complaint log of the alleged abuse.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately. [s. 101. (1) 1.]

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.