



**Ministry of Health and  
Long-Term Care**

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

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

**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 soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 21, 2016	2016_254610_0010	006490-16	Critical Incident System

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**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

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**Long-Term Care Home/Foyer de soins de longue durée**

COUNTRY TERRACE  
10072 Oxbow Drive R.R. #3 Komoka ON N0L 1R0

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

NATALIE MORONEY (610)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 11, 12, 14, 2016**

**This Critical Incident was related to Responsive Behaviours and Prevention of Abuse, Neglect and Retaliation.**

**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:  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**

**2 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 24. Reporting certain matters to Director**



**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee failed to immediately report suspicion and the information upon which it was based to the Director related to abuse of a resident by anyone.

A review of resident # 004 documentation showed alleged abuse.

The homes policy on Investigation Procedures:

“Each allegation or incident of resident neglect or abuse shall be taken seriously and immediately investigated.”

This incident was not found in the Critical Incident system when reviewed.

The Administrator # 103 confirmed that the home failed to follow the policy “ Reporting Incidents of Abuse” and that home did not report the incident to the Director. [s. 24. (1)]



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***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 licensee immediately reports suspicion and the information upon which it was based to the Director related to abuse of a resident by anyone, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**

**Every licensee of a long-term care home shall ensure that,**

**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**

**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**



1. The licensee failed to ensure procedures and interventions developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of resident # 006's documentation showed that the resident had behaviours.

The homes policy Security Check Flow Sheet:

“It is the responsibility of the Registered Nursing staff to ensure adherence of the security checks policy”.

The Nurse # 112 confirmed that staff were not completing the frequent checks and monitoring the resident.

The Medication Mapping Policy:

“...potential or actual responsive behaviours shall have their medication administration mapped as per the Supportive Measures protocols.

Medication mapping shall occur for a minimum of 72 hours...”

A review of the resident's health care records revealed that the monitoring Form was initiated but was not completed.

The Behavioural Support Nurse (BSO) # 112 revealed that behavioural mapping was initiated and should have been completed by the registered staff.

These medication mapping and check interventions were not implemented. The purpose of these interventions was to minimize the risk of altercations or potentially harmful interactions. [s. 55. (a)]



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***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 procedures and interventions developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.***

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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.**