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 soins de longue durée

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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
Aug 24, 2016	2016_276537_0030	021490-16/018928-16	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

NANCY SINCLAIR (537), ALI NASSER (523)

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): July 22 and 27, 2016

The following Complaint Inspections were completed concurrently during this inspection:
Log #018928-16 and #021490-16/IL-45195-LO/IL-45287-LO regarding care conference dates, skin and wound concerns, care provided as per the plan of care, assessments and positioning techniques
Log #022155-17 complaint regarding medication administration, assessment and care provided.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Resident Services Coordinator, Clinical Care Coordinator, one Registered Nurse, two Personal Support Workers, one resident and a family member.

During the course of the inspection, the inspector(s) also observed residents and care provided to them, reviewed a plan of care and health care record for an identified resident, policies, procedures, contracts and care conference schedules.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. (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).

Findings/Faits saillants :

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

Review of the eMAR for an identified resident indicated that the resident was to have diagnostic interventions completed and recorded daily. The Acting Director of Care #107 stated that it was expected that the eMAR would be signed and results of the diagnostic interventions would be documented in a specified location in med-e-care once completed. Review of the eMAR and med-e-care for specified dates did not include staff signature for the completion of or corresponding documentation of the results of the diagnostic intervention. Interview with the Acting Director of Care # 107 suggested that this diagnostic intervention may have been completed and documented in alternate places within the clinical record. Inspector #537 and the Acting Director of Care #107 reviewed the clinical record for this resident and were unable to find documentation to support that diagnostic intervention had been completed on the dates specified and the Acting Director of Care #107 concluded that the task had not been completed.

The Acting Director of Care #107 stated that this had not been completed as per the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

An initial care conference for an identified resident was booked for a date that was more then six weeks after the admission of the resident.

During an interview with the Resident Care Coordinator, #101, they stated that initial care conferences are to be booked within six weeks of admission, and that the care conference date booked for the identified resident was considered to be the required six week care conference, and that a care conference had not been scheduled within six weeks of admission.

The Administrator stated that the care conference booked for the resident was considered to be the initial care conference and had not been scheduled within six weeks of admission. [s. 27. (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 to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The licensee has failed to enter into the appropriate written agreement under section 83 with every physician retained or appointed under subsection (2) or (3).

Section 83 stipulated that where a written agreement between a licensee and a physician is required under subsection 82 (4), the agreement must provide for, at a minimum, (a) the term of the agreement; (b) the responsibilities of the licensee; and (c) the responsibilities or duties of the physician, including, (i) accountability to the Medical Director for meeting the home's policies, procedures and protocols for medical services, (ii) provision of medical services, and (iii) provision of after-hours coverage and on-call coverage.

A review of the home's Attending Physician 3 Year Agreement was completed on July 22, 2016 with Administrator #101. A review of the agreement revealed that the agreement was signed on February 21, 2013.

#6.0 in the agreement stated: "This Agreement shall remain in effect for three (3) years from the date first written above, or, until one of the parties give 90 days' written notice to the other party to terminate or renegotiate the Agreement, unless there is a fundamental breach of this Agreement by the Medical Director or by the Home, in which case the agreement may be terminated upon (30) days' written notice by the party not in default of the Agreement".

Administrator #101 said in an interview that she thought the agreement was already renewed and signed with the physician in February 2016, when the agreement had expired. Administrator said that the contract now has been expired for several months and she would be arranging for the new agreement to be completed as soon as possible. [s. 82. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 214. Medical Director

Specifically failed to comply with the following:

s. 214. (1) Every licensee of a long-term care home shall enter into a written agreement with the Medical Director for the home that provides for at least the following:
1. The term of the agreement. O. Reg. 79/10, s. 214 (1).
2. The responsibilities of the licensee. O. Reg. 79/10, s. 214 (1).
3. The responsibilities or duties of the Medical Director under clause 72 (3) (b) of the Act, as set out in subsection (3). O. Reg. 79/10, s. 214 (1).

Findings/Faits saillants :

1. The licensee has failed to enter into a written agreement with the Medical Director for the home that provides for at least the following: the term of the agreement, the responsibilities of the licensee and the responsibilities or duties of the Medical Director.

A review of the home's Medical Director Agreement was completed with Administrator #101 on July 22, 2016. A review of the agreement revealed that the agreement was made on June 4, 2015.

#10.0 in the agreement stated: "This Agreement shall remain in for one (1) year from the date first written above, or, until one of the parties give 90 days' written notice to the other party to terminate or renegotiate the Agreement, unless there is a fundamental breach of this Agreement by the Medical Director or by the Home, in which case the agreement may be terminated upon (30) days' written notice by the party not in default of the Agreement".

Administrator #101 said in an interview that she thought the agreement was for three years and not one, that the contract had been expired for over a month, and she would be arranging for the new agreement to be completed. [s. 214. (1)]

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Issued on this 25th day of August, 2016

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

Original report signed by the inspector.