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

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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_263524_0024	022907-17	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

INA REYNOLDS (524), HELENE DESABRAIS (615), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 2017.

The following intakes were completed within the RQI:
Log # 026405-16 Follow-up to Compliance Order #001 related to duty to protect and Compliance Order #002 related to policies.
Log # 023639-16 IL-45897-LO Complaint related to safe and secure home.
Log # 027926-16 IL-46649-LO Complaint related to continence care and housekeeping.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Assessment Instrument (RAI) Coordinator, the Environmental Services Manager, the Life Enrichment Coordinator, one Registered Nurse, eight Registered Practical Nurses, one Nurse Manager, seven Personal Support Workers, one Housekeeping staff, the Residents' Council Representative, 20 residents and three family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, relevant policies and procedures of the home, 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
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_276537_0029	524
O.Reg 79/10 s. 8. (1)	CO #002	2016_276537_0029	524

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. 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On a specific date and time, during Stage 1 of the Resident Quality Inspection, the Inspector interviewed an identified resident. When the resident was asked if the home was clean, the resident stated "not as it could be, it's old here."

Review of an Infoline complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, stated the complainant reported the cleanliness of the building was poor and lacking.

Observations on October 2, 2017, by the Inspector found the following: the home's ceiling lights in a common area had dead insects in the fixtures; and a hallway had black sticky marks on the baseboard and dark brownish dirt was observed on the floor. An identified dining room had dead insects in the ceiling fans, and the lower wall of the baseboard was dirty. Another identified hallway had brownish stains. A lounge in a hallway had one ceiling light with five dead insects and the baseboards were dirty and brownish in colour.

Observations on October 2, 2017, by another Inspector found the following: windows in a dining room were dirty with cobwebs and debris noted on the window sills; one screen was partially off and had cobwebs on it. Areas around the baseboard were dirty. In the dining room by a specific door there was a pile of dirt and debris that was present throughout the inspection. The area by the servery had caked on debris in the grout line at the base board. An identified window leading to a wing had cobwebs and a dead spider was on the window ledge; this area remained the same during the inspection.

Observations on October 5, 2017, with the Administrator noted the following:
- A pile of dirt/debris was noted by specific doors; multiple identified window sills were dirty and cobwebs were present in the sills; the wall under the servery had stains/spills and dirt that was in the grout around the baseboard and up the wall; and the corners of identified doors were blackened with dust noted in the corners;
- Dust was noted on window ledges in multiple resident rooms;
- A bathroom in an identified resident room had a strong odour and there were stains on

the floor; black areas were noted on the floor around a door;
- Bugs were noted in the ceiling lights and a window ledge in a resident room;
- The lounge on a wing had dirt and debris on the lower windows to the hall;
- The doors to an identified wing had dirt and debris noted in the corners of the doors and on the black tape across the floor;
- Both sets of a double door in a wing had blackened areas around the corners and also had dirt and debris in the corners;
- The exit door at the end of a hall was dirty; the window ledge had cobwebs; and dirt was noted at the entrance of a door;
- A nursing station had dirt built up around the baseboards.
During the tour with the Administrator and the Inspector, the Administrator acknowledged the areas of concern were not clean.

The home's housekeeping policies were reviewed and noted the following:
-"Resident Rooms - Daily Cleaning" #ENV-HK-8.1 dated June 2015, stated to "wipe all furniture, window sills, and ledges with disinfectant solution."
-"Resident Rooms - Major cleaning" dated January 2014, stated that "all windows are to be cleaned" and "screens are to be removed and damp cleaned.
-"Entrances and Lobbies" dated June 2015, stated that "high dusting must be completed on a weekly frequency or more often as required" and that "metal door frames are to be cleaned and polished on a daily frequency."
-"Nursing Stations" dated June 2015, stated "the cleaning of the nursing station should be performed daily."

Review of the home's policy titled "Dining Rooms and Kitchenettes" dated June 2015, stated "to ensure all dining rooms and kitchenettes are clean and disinfected before and after each meal. Routine cleaning practices of the dining rooms help to ensure that proper infection prevention and control has occurred and also provides for a safe and pleasant dining experience." The policy also stated to "spot clean all wall and window sills daily, or more often if required."

Review of the eight week "Work Routine" for identified home areas showed that staff were to "thorough clean" a specific room each day. One of the daily tasks was to "Clean window and screen by elevator; and, clean radiators and floor underneath radiators."
Review of the work routine for an identified housekeeping/laundry shift stated that on a particular week day staff were to "clean indoor windows as needed."

On an identified date, the Environmental Services Manager (ESM) stated that they had

no audits in place for the common areas of the home; these areas were audited visually but there was no formal documentation. The ESM and the Inspector toured the home and the ESM acknowledged that the doorways and baseboards in the hallways were not clean. The ESM acknowledged that an identified nursing station was not clean. On tour with the Inspector, it was noted that a specific doorway and under the counters had a black colour buildup, another nursing station was also reviewed and had debris under the desk and around the baseboard. During the tour, the ESM acknowledged that there were insects in some lights in the common areas. The ESM stated that every room had a thorough clean once every eight weeks. Staff had a sign off list that they completed and signed. The ESM stated that the common areas were completed by a specific shift, as part of their routine.

On another specific date, a tour was completed with the the ESM of a dining room and the window ledges and a stairwell. The ESM acknowledged that the windows had cobwebs and debris in them and one of the windows was dirty. The EMS acknowledged that the stairwell leading to a specific area was not clean. The ESM acknowledged that the window and ledge of a common area had cobwebs and debris on them.

On an identified date, the Administrator stated that the window ledges were to be cleaned each day in the residents' room. The Administrator stated that they had a meeting with the housekeeping staff that day regarding cleanliness of the resident rooms. The Administrator stated that they had called someone to replace the floor in an identified resident's room, and that they had previously changed the flooring. The Administrator stated that they were going to work on their housekeeping routines and processes.

The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

The scope of this area of non-compliance was widespread and the severity was determined to be minimum risk. The home had related non-compliance in the last three years as it was previously issued as a Written Notification on November 23, 2015, under inspection #2015_254610_0049. [s. 87. (2) (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 procedures are developed and implemented for cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

During the medication administration observation on a specific date and time, a Registered Practical Nurse (RPN) was observed preparing a resident's medication in the dining room, then walked into the dining room away from the cart and left the medication cart unlocked. Approximately 27 residents were sitting in the dining room and three residents were sitting beside the medication cart at that time.

A review of the home's Medical Pharmacies "Medication Storage" Policy 3-4 dated February 2017, stated that "when medication carts are used to store all currently required medications, carts are to be locked at all times when not attended by nurse."

During an interview, the RPN stated that they forgot to lock the medication cart and that it was the home's expectation to lock a medication cart at all times.

During an interview, the Registered Practical Nurse Initiative (RPNI) stated that when a nurse walked away from a medication cart, the cart should be locked. The RPNI said that the home's expectation for all registered nurses and registered practical nurses was to lock the medication cart when unattended.

During an interview, the Administrator stated that the home's expectation was to lock the medication cart at all times.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for actual harm. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on January 5, 2015, under Inspection #2015_217137_0001. [s. 129. (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 that drugs stored in a medication cart is secure and locked, to be implemented voluntarily.

WN #3: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

On a specific date and time, a medication cup with liquid was noted to be sitting on top of the medication cart in an identified nursing station. A Registered Practical Nurse (RPN) was sitting at the table beside the medication cart. The inspector noted that the RPN then proceeded to the cart and poured the liquid into a cup, that another staff member was holding. The other staff member then left the area with the cup. The Inspector asked the RPN what was poured into the cup and the RPN stated that it was an identified medication. When asked who the other staff member was, the RPN stated that it was a Personal Support Worker (PSW). The RPN stated that "it is not the usual, for a PSW to give our medications but an identified resident's family member asked for it to be given." The RPN stated that "if the family gave it, then they believed it was okay." The RPN stated that they would also follow up with the resident, and acknowledged that this was not the normal procedure.

Review of the resident's Medication Administration Record for a specific date, showed that the RPN had signed as the person administering the medication at a specific time.

The PSW stated that the resident's family member was there and that the resident would not take the medication earlier, and thought that if it was in the juice the resident would take it. The PSW acknowledged that the nurse poured the medication into the cup and that at times they had been asked to give medications before. The PSW stated that they had only given liquid medication before but not pills to the residents.

On a specific date and time, the Director of Nursing stated that it was “not acceptable, for a nurse to give medications to a PSW to give to the resident." The DOC stated that the identified liquid was considered a medication. During an interview with the Inspector, the Administrator stated that they were aware that the RPN had asked a PSW to administer a medication to a resident. The Administrator stated that the home’s expectation was that only registered staff could administer medication to residents.

The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for actual harm. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on November 23, 2015, under Inspection #2015_254610_0049. [s. 131. (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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home’s Medical Pharmacies "Medication Incident Reporting" Policy 9-1 dated February 2017, stated that “Every medication incident and adverse drug reaction involving a resident (excluding near misses) is to be reported to the resident or the resident’s substitute decision-maker, the Director of Nursing and Personal Care, the resident’s attending physician and the pharmacy/Clinical Consultant Pharmacist”.

A review of the last three months medication incidents and analysis for July, August and September 2017, showed that 13 medication incidents reports were completed by the home. Of those 13 medication incidents reports, seven reports did not mentioned that the family/substitute decision-maker (SDM) and attending physician who was the prescriber of the drug and the Medical Director were notified.

During an interview, the Director of Care (DOC) stated that the seven medication incidents were not reported to the SDM and physician and further stated that the SDMs and the physician were not consistently notified when a medication incident occurred. During an interview, the Administrator and DOC said that the home's expectation was that when a medication incident occurred that the registered staff were to notify the SDM and the physician.

The scope of this area of non-compliance was a pattern and the severity was determined to be minimum risk. The home had no related non-compliance in the last three years. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

An anonymous complaint report was received by the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to an identified resident's incident.

A review of the resident's progress note for an identified date, stated that an incident occurred when the resident was not monitored by staff. No injuries were noted to the resident. The progress note further stated that the "writer called administrator and informed" them of the incident.

Inspector reviewed the Critical Incident System (CIS) reports submitted to the MOHLTC and there was no evidence to support that the home had submitted a CIS report related to the resident's incident.

During interviews, the Administrator and DOC reviewed the resident's progress notes for the identified date, and acknowledged that the incident should have been reported to the Director.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years as it was previously issued as a Written Notification on November 23, 2015, under Inspection #2015_254610_0049. [s. 107. (3) 1.]

Issued on this 28th day of November, 2017

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

Original report signed by the inspector.