Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 19, 2024	
Inspection Number: 2024-1004-0002	
Inspection Type: Post-Occupancy	
Licensee: Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership	
Long Term Care Home and City: Country Terrace, Komoka	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature**
Additional Inspector(s) Julie Lampman (522) Tatiana McNeill (733564) Inspector #000821 and Inspection Manager #754 were also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 21, 27 and March 5, 7, 8, 2024
The inspection occurred offsite on the following date(s): March 6, 2024

The following intake(s) were inspected:

- Post Occupancy Inspection

Inspection 2024-1004-0001 was also completed concurrently with this inspection.

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The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and response system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(e) is available in every area accessible by residents.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system in every area accessible by residents.

Rationale and Summary
Two areas of the new building of the home did not have an emergency response call system.

The Acting Administrator (AA) confirmed that residents did access these areas and there was no resident-staff communication system available.

There was risk to all residents who accessed this area of the home of not being able to communicate with staff if needed.

Sources: Observations of resident areas; Interview with the AA. [740898]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal were posted.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes of April 2022, revised September 2023, stated under section 9.1: The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include:
e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident's care plan stated that the resident had specific infectious diagnoses. It was noted that a small yellow hexagon symbol was taped beside the resident's name plate. No directions or wording was on this symbol.

The IPAC Lead confirmed additional precautions were required for this resident. They also stated that the proper signage had not been moved over from the original building since the move on February 5, 2024.

The Acting Administrator (AA) confirmed that the type of additional precautions and required PPE should be posted on signage on the resident's door.

There was risk to residents related to unclear directions for additional precautions.

Sources: Observations of resident rooms; interviews with IPAC lead and the AA. [740898]