Ontario

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

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

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

Public Report

Report Issue Date: May 2, 2025

Inspection Number: 2025-1004-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Omni Quality Living (Country Terrace) Limited Partnership by its general partner, Omni Quality Living (Country Terrace) GP Ltd.

Long Term Care Home and City: Country Terrace, Komoka

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 28, 29, 30, May 2, 2025
The inspection occurred offsite on the following date(s): May 1, 2025
The following intake(s) were inspected:

- Intake: #00141022 - Follow-up #: 1 - FLTCA, 2021 - s. 3 (1) 11 Residents' Bill of Rights
- Intake: #00141023 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) Duty of licensee to comply with plan
- Intake: #00143146 - CI 0907-000013-25 Enteric Outbreak.
- Intake: #00144534 -CI 0907-000014-25 Alleged staff to resident abuse.
- Intake: #00146174 -CI 0907-000016-25 Alleged staff to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1004-0001 related to FLTCA, 2021, s. 3 (1) 11.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #002 from Inspection #2025-1004-0001 related to FLTCA, 2021, s. 6 (7)

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
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of licence

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Compliance Order #002, from inspection 2025-1004-0001, issued on February 26, 2025 with a compliance due date of March 28, 2025 to FLTCA, 2021 s. 6(7), was not complied with.

The following conditions of the order were not completed:

5.Provide specific education to staff in one specific home area. Keep a record of the education, date completed, who completed it, and the staff who received the education.

The Director of Care (DOC) confirmed that there were staff who not completed the required education.

Sources: Review of training records and interview with the DOC.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP # 001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
In the past 36 months, there is one Compliance Order (CO) for FLTCA, 2021, s. 6 (7) issued February 26, 2025 and one Written Notification (WN) for FLTCA, 2021, s. 6 (7)

issued December 11, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must:

A) Review and revise the home's Zero Tolerance of Abuse and Neglect of Residents policy, to ensure that the requirements/expectations for follow-up care related to any alleged incident of resident abuse as defined in the policy is clear. The policy must include, but not limited to, the

following items: Updates to the written plan of care; interdisciplinary meetings and referrals; appropriate assessments; and emotional support provided.

B) Provide training to all management and registered staff on the revised policy (part A). Maintain a documented record of the education provided, including the education content, names of staff members, and dates the education was provided.

C) Audit every new alleged, witnessed or suspected incident of abuse to ensure that resident(s) are provided support and treatment, and the revised policy is followed. The home must maintain a record of the audit, which includes the name of the person completing the audit, the sections of the policy reviewed, any parts of the policy not completed, and any corrective action taken, until this compliance order is complied by an inspector.

Grounds

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied.

Specifically, the licensee failed to ensure that staff complied with the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents – Policy #OP-AM-6.9", Reviewed March 11 2025, which stated that when a staff member witnessed, suspected or heard about an act of abuse, the first course of action would be to ensure the resident was taken to a safe and secure environment. In addition, the following steps were to be taken: providing the resident with one on one supportive measures; and assessing the needs for advanced medical assessment and treatment including psychosocial or physical intervention.

A) The management of the home received a report of an allegation of resident abuse. The resident's clinical records did not indicate that the resident received any immediate support or assessment after the alleged incident occurred. The DOC confirmed that the home did not provide additional measures to safeguard or protect the resident after the allegation of abuse.

There was a moderate risk to the resident when there was no documented assessment or support provided to the resident after the incident of alleged abuse.

Sources: Clinical records, The home's Zero Tolerance of Abuse and Neglect of Residents policy, and interviews with staff members and the DOC.

B)The management of the home received a concern/complaint report of an allegation of resident abuse. The resident's clinical records did not indicate that the resident received any immediate support or assessment after the alleged incident occurred. The DOC confirmed that the home did not provide additional measures to safeguard or protect the resident after the allegation of abuse.

There was a moderate risk to the resident when there was no documented assessment or support provided to the resident after the incident of alleged abuse.

Sources: Clinical records, The home's Zero Tolerance of Abuse and Neglect of Residents policy, and interviews with staff members and the DOC.

This order must be complied with by June 20, 2025

COMPLIANCE ORDER CO #002 Licensee must investigate, respond and act

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that:

A) Acting together as a team, including a representative from OMNI Quality Living, the Director of Care and Executive Director (and any additional persons, as applicable) must immediately investigate the allegations of abuse towards the resident identified, as per the home's investigation procedures policy. The investigation must be documented and maintained in the home until this compliance order is complied by an inspector.

B) Acting together as a team, including a representative from OMNI Quality Living, the Director of Care and Executive Director (and any additional persons, as applicable) must immediately investigate the allegations of abuse towards an additional resident, as per the home's investigation procedures policy. The investigation must be documented and maintained in the home until this compliance order is complied by an inspector.

Grounds

The licensee has failed to ensure that allegations of abuse towards residents were immediately investigated.

A)The home submitted Critical Incident System (CIS) report to the Director, which detailed an allegation of abuse by staff members towards a resident. No records of immediate investigation related to these incidents were provided to the Inspector.

Staff members who were identified as working the date of the alleged incident confirmed that they were not interviewed as part of the investigation. The DOC confirmed that they had been advised by corporate to not investigate the incident.

There was moderate risk to resident safety when the alleged incident of abuse was not immediately investigated.

Sources: Critical Incident System (CIS) report, resident clinical records, interview with staff members, the home's Investigation Procedures policy, records of communication between corporate (OMNI) and management.

B) During the inspection, it was identified that an incident of alleged abuse by a staff member towards another resident had occurred. The DOC confirmed that the home had not initiated an

investigation into the alleged incident of abuse.

There was moderate risk to resident safety when the alleged incident of abuse was not immediately investigated and a secondary incident was not reported.

Sources: Interviews with staff members, the home's Investigation Procedures policy, documented communication between the home and corporate (OMNI).

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

A) Provide re-training to involved staff members and all management of the home and any corporate representatives that may assist with allegations of abuse investigations, on the following:
-The home's Zero Tolerance of Abuse and Neglect Policy (specific to reporting allegations of abuse)

-Investigation Procedures Policy
-The Whistleblowing Protection Policy and Procedures
-The duty to report under section 28 (1) of the Fixing Long-Term Care Act, 2021
-The Resident's Bill of Rights

B) Maintain a documented record of the education provided, including the education content, the names of the attendees, dates of the training.

Grounds

The licensee has failed to ensure that when they had grounds to suspect abuse towards residents, that the information was immediately reported to the Director.

A) The licensee has failed to ensure that when staff members had grounds to suspect abuse resulting in a risk of harm to a resident, that the information was immediately reported to the Director. Pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

As part of the internal reporting protocol specified in the home's "Zero Tolerance of Abuse and Neglect of Residents" policy, any person who had reasonable ground to suspect that a resident had been abused was obligated to immediately report the suspicion and information to the home's Executive Director or manager on call, as well as to the Director (Ministry of Long-Term Care).

Staff members of the home allegedly witnessed an incident resident abuse and it was acknowledged that the incident should have been reported immediately.

Sources: Interviews with staff members, the home's Critical Incident Systems (CIS) report, the home's Zero Tolerance of Abuse and Neglect of Residents Policy.

B) The licensee failed to ensure that when staff had reasonable grounds to suspect

that a staff member was verbally towards a resident, that they immediately reported the suspicion to the Director. Pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

The management of the home confirmed they had been informed of an allegation of abuse by a staff member towards a resident. The DOC confirmed that the staff member reported the incident to management late, and there was no Critical Incident Systems (CIS) report submitted to the Director.

Sources: The Ministry of Long-Term Care Critical Incident System reporting portal, the home's Reporting Incidents of Abuse policy, interviews with staff members, and complaint/response documentation.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that:

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes,

most recent edition, is reviewed by the home's IPAC lead and DOC. Keep a signed acknowledgement of this review as well as the content and the date it was completed.
B) All direct care staff complete education related to hand hygiene for staff and residents. This education must be documented with date and times of education, who attended, who provided the education and the contents of the education.
C) Once education has been completed as above, audits are performed at one meal service daily for two weeks on residents being assisted with hand hygiene on specific home areas. Alternate which meal this is done in order to capture all 3 meals. Once the initial two weeks of audits is complete, then twice weekly audits are to be performed on both home areas until this order is complied by an inspector. Documentation with the contents and outcome of the audits, any actions taken including any education provided, dates, times and who completed the audits are to be kept and available.

Grounds

The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, revised September 2023, was implemented, specifically the following areas:

A) The IPAC Standard required under section 10.2 that the hand hygiene program was to include hand hygiene support for residents, specifically (c) assistance to residents to perform hand hygiene before meals.

During an observation of a meal service, it was noted that multiple residents were not provided assistance or supported to perform hand hygiene prior to eating. Staff placed a Sani Health Hand Sanitizer wipe at each place setting but did not assist any residents. Many residents did not use the wipe or acknowledge it was set in front of them.

At the beginning of a meal service, staff proceeded to pass out Certainty Wipes to

each resident and instructed them to wash their hands. No residents were provided assistance. Some residents completed hand hygiene with the wipe and some did not. An additional staff member placed Sani Health Hand sanitizing wipes at resident place settings and also did not provide assistance or instruction to any residents.

IPAC lead acknowledged that staff had been using Certainty Wipes for hand hygiene for residents and that they do not contain alcohol as required.

There was risk to the residents in the home for transmission of infectious disease due to the lack of proper hand hygiene.

Sources: Home area and staff observations, review of the IPAC Standards, interview with staff and the home's IPAC lead.

B) The IPAC Standard required under section 9.1 - The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During an observation of a meal service, it was noted that one staff member did not perform hand hygiene for the entire meal service. This staff member was serving meals, clearing dirty dishes, cutlery, napkins and assisting to set up resident meals including handling food items.

Two additional staff members were observed to assist residents to eat, then finished and moved to another table to provide assistance to feed an additional resident. Both staff members did not perform hand hygiene after assisting one resident and before starting the next resident. This occurred twice for each staff member.

There was risk to the residents in the home for transmission of infectious disease due to the lack of hand hygiene.

Sources: Meal service and staff observations, review of the IPAC Standards, interview with the home's staff and IPAC lead

C) The IPAC Standard required under section 4.3, The licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

The IPAC lead confirmed that following the resolution of an enteric outbreak, the home's OMT and the home's interdisciplinary IPAC team did conduct a brief discussion related to the enteric outbreak at the morning meeting, but a summary was not done and recommendations not discussed or shared with the licensee.

Sources: Critical Incident, Outbreak file and interview with the IPAC lead.

This order must be complied with by June 20, 2025

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.