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: June 10, 2025

Inspection Number: 2025-1004-0005

Inspection Type:
Complaint

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): May 29, 30, 2025 and June 2, 4, 6, 9 and 10, 2025
The inspection occurred offsite on the following date(s): June 3, 5, 2025

The following intake(s) were inspected:

- Intake: #00147436 - related to fire safety in the home.

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

Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that the doors to three non-resident areas were locked when not being supervised by a staff member.

Inspector observed three office doors in the hallway to be unlocked and open. No staff or residents in the area at the time.

The Director of Care (DOC) stated that the hallway was accessible to residents but the offices were non-resident areas and therefore the doors were to be closed and locked when unsupervised by staff.

Sources: Observations, interview with Director of Care. [740898]

COMPLIANCE ORDER CO #001 Training

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

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

Specifically the licensee must;
a) The Licensee shall provide training to all staff members of the home including all designations and volunteers on the current code red fire policy and current fire safety plan.
b) Using a current all staff list and list of current volunteers, document the date that each staff member received the training, keep a record of the contents of the training provided and who provided the training.

Grounds

The licensee failed to ensure that all staff received annual retraining in the current version of the home's fire policy and the current fire safety plan.

In the regulations, as mandated in O Reg 246/22, s. 260. (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The home had undergone major redevelopment in 2025 that changed the fire safety plans.

The most current version of the home's code red fire code policy was dated April 7, 2025.

The Director of Care (DOC) confirmed that the fire code policy on surge learning that staff received training in was dated February 5, 2024.

DOC confirmed that the only mandatory annual training that all staff received was through surge learning and it did not include the fire safety plan.

During a review of the records of training, it was identified that instruction on the annunciator panel and location of the fire was not included in the annual mandatory

training.

All residents of the home were at an increased risk related to the staff in the home not being trained on the Fire Safety Plan and the most up to date version of the Code Red Fire Policy.

Sources: record review surge education records, fire safety plan, code red policy, interviews with DOC, Administrator and other staff. [745]

This order must be complied with by August 5, 2025

COMPLIANCE ORDER CO #002 Emergency plans

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 90 (1) (a)
Emergency plans
s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must;
a) Ensure the current code red fire policy and current fire safety plan, are accessible to all staff on all home areas as per established location.
b) The licensee shall designate a responsible person to ensure this location is updated with a current fire safety plan or a current code red fire policy any time a

change is made to the emergency plans and a documented record kept of when it was replaced and by whom.

Grounds
The licensee failed to ensure that there were updated emergency plans specifically fire safety plans in place for the home and accessible to the staff that comply with the regulations.

Record review of the fire safety binder on each home area identified a fire safety plan dated November 1, 2023, and not the most updated version dated February 21, 2025.

Record Review of the emergency preparedness plan binders on each of the four home units identified an outdated emergency plan or no plan available to the staff to reference.

During interviews with registered staff they stated they would use the fire safety binder as their resource in a fire emergency.

Director of Care and Administrator confirmed the fire safety binder should have the most recent fire safety plan in it, for staff to access.

Sources: record reviews including fire safety plan, emergency preparedness plan, and interviews with registered staff, DOC and Administrator. [745]

This order must be complied with by June 23, 2025

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #003 Emergency plans

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (8)
Emergency plans
s. 268 (8) The licensee shall ensure that the emergency plans for the home are evaluated and updated,
(a) at least annually, including the updating of all emergency contact information of the entities referred to in paragraph 4 of subsection 268 (4); and
(b) within 30 days of the emergency being declared over, after each instance that an emergency plan is activated.

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

Specifically the licensee must;
a) Review and revise their process to ensure the fire safety plan is evaluated and updated within 30 days after each instance that the emergency plan is activated including but not limited to fire alarms.
b) Keep a record of this review, the date completed, who participated and changes made.
c) Keep a record of each evaluation completed after the emergency plan is activated.
d) Review and evaluate each instance in 2025 the emergency plan was activated, keep a record of this review, who participated, the date completed and outcome of review.

Grounds
The licensee failed to ensure that the emergency plan, specifically the Fire Safety

Plan was evaluated and updated within 30 days after each instance that a fire alarm was activated.

An email confirmed 22 fire alarms were recorded from 2023 to June 10, 2025.

The home was unable to provide any evaluations and updates that were completed after these 22 instances of the emergency plan being activated.

Interviews with Environmental Services Manager (ESM) and Director of Care (DOC) included they did not participate in post fire alarm evaluations or updates to the fire safety plan.

Administrator confirmed they had no documentation of evaluations or updates to the emergency plan or specifically the fire safety plan after instances of the plan being activated.

Sources: record review and interviews with ESM, DOC and Administrator. [745]

This order must be complied with by June 23, 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.