

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: August 13, 2025

Inspection Number: 2025-1004-0008

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): August 11, 12 and 13, 2025

The following intake(s) were inspected:

- Intake: #00148872 - Follow-up #: 1 - O. Reg. 246/22 - s. 93 (2) (b) (ii)
- Intake: #00149699 - Follow-up #1 - FLTCA, 2021 - s. 82 (4) Training
- Intake: #00150275 - Follow-up #1 - FLTCA, 2021 - s. 24 (1) Duty to Protect
- Intake: #00153519 - Follow-up #: 2 - FLTCA, 2021 - s. 27 (1) (a) (i)
- Intake: #00153520 - Follow-up #: 1 - O. Reg. 246/22 - s. 140 (1)
- Intake: #00154537 - related to falls prevention

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1004-0005 related to FLTCA, 2021, s. 82 (4)

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Order #001 from Inspection #2025-1004-0006 related to FLTCA, 2021, s. 24 (1)

Order #002 from Inspection #2025-1004-0002 related to FLTCA, 2021, s. 27 (1) (a)
(i)

Order #002 from Inspection #2025-1004-0007 related to O. Reg. 246/22, s. 140 (1)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order # 001 from Inspection #2025-1004-0004 related to O. Reg. 246/22, s. 93 (2)
(b) (ii)

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

- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

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The licensee has failed to ensure that the planned care for a resident was included in the resident's written plan of care specific to falls interventions.

A resident was observed to have falls interventions in place that were not identified in their plan of care.

Sources: Resident clinical records; the home's Resident Falls and Post Fall Assessment policy; and interview with the falls lead.

WRITTEN NOTIFICATION: Conditions of License

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of license

s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

The licensee failed to meet all requirements of Compliance Order #001 from inspection 2025-1004-0004, issued on May 30, 2025, with a Compliance Due Date (CDD) of July 25, 2025, related to O. Reg. 246/22 - s. 93 (2) (b) (ii), Housekeeping.

The following conditions of the order were not completed:

1. Review the home's Reprocessing Policy #: IPAC-RM-10.2 to ensure direction to staff is clear on the process they are to follow. Revise as necessary. Keep a written record of any revisions made.

The Director of Care (DOC) confirmed that the home's management and corporate

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team had done a review of the Reprocessing Policy #: IPAC-RM-10.2 and identified some revisions needed to the portion of the policy titled "Reprocessing Procedure document for Bed Pans, Commode pans, Urinal Reprocessing Procedure" and had added "Tub and Shower Chair Cleaning" procedure at the home level. The original noted policy did not have the revisions made nor was the review or revision date updated on the policy and this was still the current policy being used in the home and available to staff for reference.

The IPAC lead stated that the directions for cleaning and disinfecting of urinals in the policy and the procedure was not the present process that the home expects the staff to follow. The correct process for cleaning and disinfecting urinals was not written out for staff in any documents the home was able to provide. Policy #: IPAC-RM-10.2 did not have clear direction for staff related to cleaning of basins, k-basins or urinals. It also did not provide direction related to weekly cleaning of resident specific equipment.

Two Personal Support Workers (PSW) both described their process for cleaning and disinfecting resident specific equipment that did not align with the home's written policy or procedure.

The DOC confirmed that the home's corporation had intention to revise the Reprocessing Policy IPAC-RM-10.2 to include an addendum for the procedure which is specific to the home but was not completed yet.

3. Develop and implement a cleaning schedule with clear direction on the process for staff to follow as per the home's Reprocessing Policy #: IPAC-RM-10.2.

Resident Equipment Cleaning Schedules were set up in a separate binder for staff on each unit of the home. There was a tracking document for basins and k-basins and one for bed pans/urinals. No written directions were included on the process for the weekly cleaning for the equipment other than that it was to be done every Sunday. No policy was referenced.

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The Reprocessing Policy #: IPAC-RM-10.2 did not have clear direction for staff related to weekly cleaning of basins, k-basins, urinals or bedpans.

On the tracking document for weekly cleaning for Woodcrest Unit, no staff had signed for completion of the cleaning of urinals and bedpans for August 11, 2025. A PSW described the weekly cleaning process that did not align with the stated process of the Infection Prevention and Control (IPAC) lead.

The DOC and IPAC lead confirmed that the cleaning schedule did not provide clear direction to staff on the weekly cleaning process.

4. Provide education with clear direction to all Personal Support Worker (PSW) staff who may work on a Unit in relation to the cleaning and disinfecting of resident specific equipment and supplies such as urinals, basins, bedpans or any other resident specific equipment. This education shall include, but is not limited to the home's Reprocessing Policy #: IPAC-RM-10.2. Keep a documented record of this education including the content, who provided the education, dates and list of attendees.

The IPAC lead confirmed that the education contents provided to staff did not include the home's Reprocessing Policy #: IPAC-RM-10.2.

There was risk to all residents who use resident specific equipment not being cleaned or disinfected as per the home's policy which increases risk of infection transmission.

Sources: Review of the home's Reprocessing Policy#: IPAC-RM-10.2, Effective Date: May 11, 2020, Reviewed Date: November 22, 2024, Approved Date: November 22, 2024, the Weekly Cleaning Schedule, the Education documents, and observations and interviews with staff.

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

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#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 #002

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 issued on May 30, 2025 related to O. Reg. 246/22 - s. 93 (2) (b) (ii), Housekeeping.

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.

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WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program was implemented when the Morse Falls Risk Assessment for a resident was not completed when required.

In accordance with O.Reg 246/22 s. 11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee was required to ensure that the program was complied with.

The home's Morse Falls Risk Assessment policy #OTP-FP-7.3, reviewed on July 2, 2025, indicated that residents would be assessed for falls risk using the MORSE Falls Risk Assessment tool with any significant change of status.

Sources: A resident clinical records; the home's Morse Falls Risk Assessment policy, # OTP-FP-7.3; interview with the falls lead.

WRITTEN NOTIFICATION: Skin and Wound Care

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, that they received a skin assessment using a clinically appropriate assessment instrument.

A review of a resident clinical records indicated that a skin assessment was not completed when required.

Sources: A resident clinical records, the home's Wound Assessment and Documentation policy, last reviewed June 24, 2025; and interviews with two registered staff members.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of \$500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s.

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155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Compliance Order (CO) #002 from inspection 2025-1004-0002 related to FLTCA, 2021 - s. 27 (1) (a) (i) Licensee must investigate, respond and act, with CDD May 30, 2025. Follow up inspection #2025-1004-0008 conducted on August 11, 2025.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.