



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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 20, 21, 22, 2012	2012_090172_0044	Complaint

Licensee/Titulaire de permis

OMNI HEALTHCARE (COUNTRY TERRACE) LIMITED PARTNERS
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

JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Physiotherapist, the Resident Care Coordinator, 2 Registered Practical Nurses, 1 Personal Support Worker and a specific Resident.

During the course of the inspection, the inspector(s) reviewed health care records, in house fall investigation, policies and procedures and other relevant documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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.)	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.)
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

- 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;
 - (b) the goals the care is intended to achieve; and
 - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Staff interviews with a Registered Practical Nurse, a Resident Care Coordinator and the Director of Care, revealed differing information as to how a transfer was to be completed for a specific resident.
2. The Care plan and Kardex did not reflect the changes made post a resident's fall, to give clear direction to the staff as to how a resident was to be transferred.
[LTCHA, 2007, S.O. 2007, c.8, s6(1)(c)]

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 the plan of care gives clear direction to the staff providing care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Chart review revealed a resident fell during a transfer from bed to chair.
2. Staff interview with the Director of Care revealed a resident fell during a transfer resulting in an injury. Since this incident, new equipment has been purchased specific to this resident.
[O. Reg. 79/10, s. 36.]

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 residents are safely transferred, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management



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Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Staff interview with Director of Care, a Physiotherapist and a Registered Practical Nurse revealed:

- a) currently the home does not use a clinically appropriate assessment instrument that is specifically designed for falls to be used when a resident sustains a fall;
- b) the home does not use the post fall assessment associated with their computerized charting program.
- c) a Registered Practical Nurse is working with Physiotherapist to develop an appropriate post fall assessment tool.

Chart review did not reveal a post fall assessment was conducted, using a clinically appropriate assessment instrument after a resident's fall.

[O.Reg.79/10,s.49(2)]

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 a clinically appropriate assessment instrument that is specifically designed for falls is used when a resident has fallen, to be implemented voluntarily.

Issued on this 22nd day of August, 2012

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

Jean L. Hodley .