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

Original Public Report

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1004-0002	
Inspection Type: Critical Incident	
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 Julie Lampman (522)	**Inspector Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2023.12.12 14:03:55 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27, 28, 29, 2023.

The following intake was inspected:

- Intake: #00095771/Critical Incident System (CIS) report #0907-000017-23 related to falls prevention and management.

The following intake was completed in this inspection:

- Intake: #00095737/CIS #0907-000016-23 related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control

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 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident had several falls. The resident's electronic Treatment Administration Record (eTAR) indicated staff were to complete vital signs, skin and pain assessments each shift for 24 hours post fall.

Pain assessments and skin assessments were not completed on certain shifts post falls.

Registered Practical Nurse (RPN) #104 stated skin assessments and pain assessments should have been completed each shift post fall for 24 hours and documented under assessments.

There was risk of staff missing post fall injuries by not completing post fall pain and skin assessments as per the resident's plan of care.

Sources:
Review of the resident's clinical records, and interviews with RPN #104 and other staff. [522]

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.
Training
Additional training — direct care staff
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas and at times or at intervals provided for in the regulations.

Rationale and Summary
O. Reg 246/22 s. 261 (1) 1. stated all direct care staff shall receive training on falls

prevention and management. The training was to be completed annually.

The home's Surge Learning Required Completion Report for 2022 noted:
-97.5% of staff had completed Falls Preventions Part 1 and 2
-95% of staff had completed Falls Preventions Part 3 and 4
-95% staff had completed the Falls Preventions: All Parts Chapter Course

The Administrator reviewed the Surge Learning Report with Inspector #522 and confirmed all staff were actively working and should have been training in Falls Prevention in 2022.

Sources:
Review of the home's Surge Learning Required Completion Report for 2022 and an interview with the Administrator. [522]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applied to the long-term care home.

Rationale and Summary
On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term

care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s.184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19.

Section 1.1 of the Minister's Directive: COVID-19 response measures for long-term care homes updated August 30, 2022, stated the licensee must conduct regular Infection Prevention and Control (IPAC) audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

A) The MLTC COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated June 26, 2023, stated the local public was responsible for all aspects of outbreak management including declaring the end of an outbreak.

Critical Incident System (CIS) report was submitted to the MLTC by the home related to a COVID-19 outbreak that was declared by the Public Health Unit (PHU).

During the entrance conference the Administrator stated that the home was still in a COVID-19 outbreak and was awaiting for the PHU to declare the outbreak over. There was no signage posted at the entrance of the home which indicated that the home was in COVID-19 outbreak.

The IPAC Lead NM stated there had been a miscommunication with registered staff and when the last resident came out of isolation they removed the outbreak signage on the front door of the home. The IPAC Lead stated they had not received notification from the PHU that the COVID-19 outbreak was declared over at the time the signage was removed.

B) The Ministry of Long-Term Care (MLTC) COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated June 26, 2023, stated when a home was in a

COVID-19 outbreak IPAC self audits must be completed weekly.

There was no IPAC self audit completed for one of the weeks the home was in outbreak.

The IPAC Lead Nurse Manager (NM) stated they completed the IPAC self audits weekly when the home was in outbreak and had not completed the IPAC self audit for a specific week.

There was no impact to residents as there were currently no active cases of COVID-19 in the home and all staff and visitors in the home were wearing masks.

Sources:
Review of a CIS report, the home's "Management of a COVID-19 Outbreak" policy #IPAC-OM-5.9 last reviewed July 12, 2023, the home's IPAC self audits and interviews with the IPAC Lead NM and the Administrator. [522]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically

appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
A resident had an unwitnessed fall and there was no post fall assessment completed for the resident. Registered Practical Nurse (RPN) #104 stated a post fall assessment was to be completed after every fall.

There was moderate risk to the resident as there was no documentation related to the resident's fall or identification of contributing factors to prevent further falls.

Sources:
Review of the resident's clinical records, the home's "Resident Falls and Post Fall Assessment" policy # OTP-FP-7.4 last reviewed March 30, 2022, and interviews with RPN #104 and other staff.
[522]

COMPLIANCE ORDER CO #001 Required programs

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

Specifically, the licensee must ensure:

A) A resident has a head injury routine (HIR) completed as per policy, when it is required.
B) A resident has vital signs and other post fall assessments completed post fall, as per policy.
C) Documentation regarding the resident's condition post fall is documented, as per policy.
C) Retrain all registered nursing staff on the home's post falls policy.
D) A record must be kept of the training, including the contents of the training, the dates of the training, the name of the trainer, and the staff members who completed the training.

Grounds
The licensee has failed to comply with the home's falls prevention and management policy related to post fall assessments and head injuries, included in the required falls prevention and management program in the home, for a resident.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Resident Falls and Post Fall Assessment" policy #OTP-FP-7.4 last reviewed March 30, 2022, related to head injury routines (HIR), assessment of the resident's vital signs, an additional assessment if the resident had a specific diagnosis and follow up documentation

post fall.

The home's "Resident Falls and Post Fall Assessment" policy stated after a resident fall, registered staff would take the resident's blood pressure, pulse, respirations, oxygen saturation, temperature and an additional assessment if the resident had a specific diagnosis. If there was any possibility of a head injury, staff were to initiate a HIR.

The policy stated follow up documentation regarding the resident's condition and any apparent effects of the fall should be entered for 24 hours post fall when a resident had not experienced an injury as a result of the fall.

A resident had several falls over a three month period.

i) As part of the resident's post fall assessment, vital signs were not taken on three occasions and a required additional assessment was not completed on six occasions.

ii) Neurological Vital Signs Post Head Injury Assessments were to be completed every 15 minutes for the first hour, every hour for three hours and every four hours for the next 20 hours. The assessment was to include vital signs, assessment of mental status, limb movement, cranial nerve, and pupillary reaction.

The resident had an unwitnessed fall and a Neurological Vital Signs Post Head Injury Assessment was initiated. On two required checks, the assessment was incomplete and 'sleeping' was documented. On another required check, the assessment was not completed and 'sleeping' was documented. There were no Neurological Vital Signs Post Head Injury Assessments completed for five of the resident's unwitnessed falls.

iii) Post fall follow up documentation was not completed for the resident on certain shifts after four falls.

Registered Practical Nurse (RPN) #104 stated an additional assessment should be completed for residents with a specific diagnosis after a fall and a HIR should be completed for all unwitnessed falls or head injuries.

Registered Nurse (RN) #105 stated staff should wake a resident if sleeping to complete a HIR and 'sleeping' should not be entered on the Neurological Vital Signs Post Head Injury Assessment.

The IPAC Lead Nurse Manager (NM) stated they had searched for Neurological Vital Signs Post Head Injury Assessments for the resident and could not find the assessments for five of the resident's falls. The IPAC Lead NM stated that a HIR should have been completed as the falls were unwitnessed. The IPAC NM stated staff should be documenting for each shift for 72 hours post fall if the resident was injured and 24 hours if there was no injury.

There was a high risk to the resident of missing post fall injuries by not completing a HIR, not checking the resident's vital signs and completing required additional post falls assessments.

Source:
Review of the resident's clinical record, the home's "Resident Falls and Post Fall Assessment" policy #OTP-FP-7.4 last reviewed March 30, 2022, and interviews with RPN #104, RN #105 and the IPAC Lead NM. [522]

This order must be complied with by January 24, 2024

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

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.