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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 20, 2013	2013_229213_0058	L-000993-13	Critical Incident System

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

RHONDA KUKOLY (213), SALLY ASHBY (520)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 19, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, 2 Registered Nurses, 1 Registered Practical Nurse, and the Community Care Access Centre Case Coordinator

During the course of the inspection, the inspector(s) made observations, reviewed electronic and paper health records and the home's internal investigation notes

The following Inspection Protocols were used during this inspection:

Admission Process
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complete before discharging a resident:
- ensure that alternatives to discharge have been considered and, where appropriate, tried;
- in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
- ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

a) Record review of a Resident's electronic health record and the home's investigation records revealed that the administrator discharged this Resident from the home immediately following an incident.
b) Record review of a Resident's electronic health record and the home's investigation records revealed that the home informed this Resident's family that the Resident was discharged from the home immediately following an incident.
d) Record review of a Resident's electronic health record and the home's investigation records revealed no evidence of alternatives to discharge that were considered or tried, no collaboration occurred to make alternate arrangements for the accommodation and care of this resident and the resident's substitute decision maker was not given an opportunity to participate in discharge planning.
e) Interview with the Director of Care confirmed that no alternatives to discharge were considered following this Resident's discharge and no discussion occurred regarding alternate arrangements for accommodation and care with this Resident's family or the Community Care Access Centre. [s. 148.]

Issued on this 20th day of December, 2013

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

Rhonda Kukoly