



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 16, 2015	2015_217137_0001	L-001649-14	Resident Quality Inspection

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

MARIAN MACDONALD (137), ALICIA MARLATT (590), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 5, 6, 8, 12 and 13, 2015

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, RAI/MDS Coordinator, Nursing Office Manager, Resident Services Coordinator, Life Enrichment Manager, Nutrition Care Manager, Environmental Services Manager, Clinical Care Coordinator, three (3) Registered Nurses, six (6) Registered Practical Nurses, eleven (11) Personal Support Workers/Health Care Aides, three (3) Dietary Aides, two (2) Housekeepers, one (1) Maintenance Worker, three (3) Family Members and forty + (40+)Residents.

The Inspectors also toured all resident home areas, common areas, medication storage area, observed dining service, care provision, recreation programs, medication administration, resident/staff interactions, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing**



During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57.
Powers of Residents' Council**

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :



1. The licensee has failed to ensure that written responses, related to concerns or recommendations from Residents' Council, were responded to within 10 days as evidenced by:

A review of the 2014 Residents' Council meeting minutes revealed:

Concerns/recommendations from the December 15, 2014 Residents' Council Meeting were responded to in writing on January 5, 2014.

Concerns/recommendations from the October 20, 2014 Residents' Council Meeting were responded to in writing on November 3, 2014.

Concerns/recommendations from the September 15, 2014 Residents' Council Meeting were responded to in writing on September 29, 2014.

Concerns/recommendations from the June 22, 2014 Residents' Council Meeting were responded to in writing on July 10, 2014.

Concerns/recommendations from the May 26, 2014 Residents' Council Meeting were responded to in writing on June 11, 2014.

The Administrator and the Life Enrichment Manager both confirmed that these responses were not provided to the Residents' Council within 10 days of receiving them.

They both indicated that they believed the home had "10 business days" to respond to all concerns and recommendations.

A review of the home's Residents' Council Terms of Reference January 2014 indicates

4. Suggestions and Concerns

The Residents' Council Assistant shall inform the Administrator and other department managers of any concerns brought forward within 48 hours of the meeting.

The Administrator shall investigate and provide a written response to the Residents' Council Assistant within ten (10) days.

The Administrator confirmed that it is the home's expectation to follow the terms of reference and legislation and that all concerns or recommendations from Residents' Council be responded to, in writing, within 10 days. [s. 57. (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 that a written response related to concerns or recommendations from Residents' Council is responded to within 10 days, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
 - (i) that is used exclusively for drugs and drug-related supplies,**
 - (ii) that is secure and locked,**
 - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
 - (iv) that complies with manufacturer's instructions for the storage of the drugs;**
 - and O. Reg. 79/10, s. 129 (1).**
 - (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

Findings/Faits saillants :



1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:

The closet door, outside of the Nottingham Place Nursing Station, was found open and contained shelves with physician ordered resident treatment creams, stored in baskets.

The Director of Care confirmed that this door should be kept locked and that the home's expectation is that all medications/drugs are to be stored in a secure area with a lock. [s. 129. (1) (a) (ii)]

2. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:

On January 5, 2014 at 2:35 pm, the Nottingham Place Nursing Station door was observed open with a treatment cart unlocked and unattended. Prescription creams were readily accessible to residents and visitors.

The RAI Coordinator confirmed that the treatment cart was unlocked and unattended, as well as the expectation that the cart be locked when unattended. [s. 129. (1) (a) (ii)]

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 that drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
 - i. persons who may dispense, prescribe or administer drugs in the home, and
 - ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator as evidenced by:

There is a drug storage room located in the basement which contains government stock medications. The Pharmacist, one Registered Practical Nurse and the Environmental Services Manager have access to this secure room.

The Environmental Services Manager and a Registered Staff Member confirmed that the Environmental Services Manager has access to the identified government stock medication drug storage room.

A Registered Staff Member confirmed that drug storage areas should only be accessed by Registered Staff and the Administrator. [s. 130. 2.]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 16th day of January, 2015

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

Original report signed by the inspector.