Ontario

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 18, 2016	2016_289550_0003	009321-14, 001835-15	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

JOANNE HENRIE (550)

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): January 5, 6, 7, 8, 11, 12 and 13, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nurses (RN), several support workers and the Behaviour Supports Ontario (BSO) person and one resident.

In addition, the inspectors reviewed residents health care records and the home's responsive behaviour program. The Inspector observed care and services and staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A critical incident was submitted to the Director on a specific date in 2014 reporting an incident of abuse that occurred on another specific date in December 2014. It was reported that resident #006 entered resident #004's room and was going to take another resident's mobility device. Resident #004 told resident #006 not to take the other resident's mobility device and resident #006 slapped resident #004 hard on a specific body part. As a result of this incident, resident #004 was emotionally upset and complained that specific body parts were sore. The critical incident report indicated that the RN #S103 was instructed by the DOC in place at that time to call the MOHLTC which was not done.

During an interview, RN #S103 indicated to Inspector #550 that the home's procedure when an incident of abuse occurs is that as the nurse in charge of the home after the managers have left the home, she is to immediately notify the DOC of incidents and that it is the DOC's responsibility to inform the Director as per their internal policy. She further indicated at the time of this incident she notified the DOC in place at that time and she does not recall that this DOC had instructed her to call the MOHLTC otherwise she would have done it.

As such, the Director was not immediately notified of this incident of resident to resident abuse.

The home's ''Zero Tolerance of Abuse and Neglect of Residents'' policy has been updated on June 2015 to incorporate that ''any person who has reasonable ground to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicions and the information upon which the suspicion is based to the Director, Home's Administrator or manager on call'' as a result of the issuance of a Compliance Order issued on June 4, 2015. [s. 24. (1)]

Issued on this 19th day of January, 2016

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

Original report signed by the inspector.