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 19, 2016	2016_289550_0002	020278-15	Complaint

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 Complaint 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) and a family member.

In addition, the inspector reviewed a critical incident report, complaints from six different family members, the resident health care records, the home's policy on consent to treatment(s) and the home's internal investigation report.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care for resident #001 is based on an assessment of the resident and the needs and preferences of that resident.

A critical incident was submitted to the Director reporting an incident on a specific date in February 2015 where RN staff #S102 had administered an injection of a specific medication to resident #001 after the resident had said he/she did not want the injection and the resident's power of attorney (POA) who was present had also indicated the same. It was reported the nurse was rude and unprofessional.

During an interview, resident #001's POA indicated to Inspector #550 that RN #S102 and RPN #S103 came into the resident's room and RN #S102 indicated she was going to administer a specific medication by injection to resident #001. Resident #001 said "No" he/she did not want the specific medication and the POA indicated to the RN she did not want the medication to be administered. The RN disregarded their refusal and administered the medication by injection anyway. Several family members were present at the time and witnessed the incident. In their written "witness report", five different witness indicated that when RN #S102 informed resident #001 and the family members present she was going to administer a medication by injection, the resident clearly indicated "no" he/she did not want the injection and the resident's POA also indicated the same. RN #S102 administered the medication by injection to resident #001 in a specific body part regardless of the resident and the POA's refusal to the treatment.

Inspector observed documented on resident #001's mar sheet a physician's order for a specific medication to be administered by injection (or by mouth or rectal) every 4 hours when required for a specific symptom and that the medication had been administered on a specific date in February 2015 by RN S#102.

During an interview, the Administrator indicated to Inspector #550 following their internal investigation, it was determined that RN #S102 did not respected resident #001's request to refuse the treatment and was disciplined.

As such, the care provided to resident #001 was not based on the preferences of that resident. [s. 6. (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 care provided to residents is based on the resident's preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, the licensee shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

A complaint was submitted to the Director through the critical incident reporting system on a specific date in February 2015 indicating that RN #S103 was approached by resident #001's substitute decision maker with a complaint regarding nursing care given to resident #001 by the night RN. Resident #001's substitute decision maker indicated that the night RN, RN #S105 had administered an injection of a specific medication to resident #001 after the resident and herself had indicated to this nurse not to administer the medication.

Inspector reviewed the home's investigation file and observed 6 "witness report" form signed and dated a specific date in February 2015 by 6 different family members. The forms were submitted to the Director of Care in place at the time of the incident that same day. The documentation of the witness reports indicated concerns about the care given to resident #001 by RN #S105 where it is reported that RN #S105 administered an injection of a specific medication to resident #001 after the resident said he/she did not want the injection and the resident's substitute decision maker who was present had also indicated the same.

During an interview, the Administrator and the actual Director of Care both indicated to Inspector #550 that they did not consider this incident as a complaint but rather an incident. The Administrator further indicated not knowing he had to submit a written report documenting the response he made to the complainant to the Director.

As such, the response the Administrator made to the complainant was not submitted to the Director. [s. 103. (1)]

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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.