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

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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_0001	012577-15, 012575-15	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 11, 12 and 13, 2016. Off site inspection was also conducted on January 14, 2016.

The inspection also included two critical incidents under Log 024076-15 and 035182-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), several registered nurses (RN), the behaviour support ontario (BSO) staff, several personal support workers (PSW), several residents and a family member.

In addition, the inspector reviewed resident health care records, policies related to abuse and reporting, the home's responsive behaviour program and registered nurses schedule. The inspector observed care and services, staff and resident interaction and meal services.

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_200148_0016	550
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #003	2015_200148_0016	550

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.

The LTCHA defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

A critical incident report was submitted to the Director on a specific date in August 2015 reporting an incident of resident to resident abuse that occurred on another specific date in August 2015; 48 hours earlier. It was reported that resident #002 grabbed resident #001's walker and shook it back and forth causing resident #001 to loose balance and fall to the floor. As a result of this fall, resident #001 complained of dizziness, sustained a red mark on a specific body part and a bruise.

The Director of Care indicated to Inspector #550 she was informed of the incident the following day and she did not immediately inform the Director of the incident because she did not think the resident had sustained any physical injuries.

During an interview, the RN staff #S103 indicated she did not immediately inform the Director or the director of care of the incident as she did not consider this incident as physical abuse.

As such, the Director was not immediately notified of this incident of physical abuse to resident #001 by resident #002. [s. 24. (1)]

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 all incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm are immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes:

any mood and behaviour patterns, including wandering
any identified responsive behaviours
any potential behavioural triggers and variations in resident functioning at different times of the day.

Resident #002 was physically aggressive towards resident #001 on a specific date in August 2015 grabbing resident #001's walker as the resident was walking and shaking it back and forth causing resident #001 to loose balance, fall and injure himself/herself.

During an interview, PSW #S101 indicated to Inspector #550 resident #002 can be physically aggressive towards residents or staffs; resident #002 yells out a lot and is very impatient. He/she has tripped staff and kicked residents who are in his/her way or just near him/her. When the resident exhibits those kinds of behaviours, staff will go see what he/she needs and tend to those needs, sit down and talk with the resident, or just

leave and return. Resident #002 often wants staff to push his/her wheelchair up and down the hall with him/her. She indicated sometimes the resident will feel remorse when aggressive with staff but never with the residents. The Director of Care indicated the resident dislikes other residents that get in his/her way.

Inspector reviewed resident #002's health records and care plan at the time of the incident. It was observed documented in the flow sheets as follows:
May 2015:
verbally aggressive: x2
physically aggressive: x0
resist care: x1
repetitive anxious complaints: x3

June 2015:
verbally aggressive: x17
physically aggressive: x2
resist care: x5
repetitive anxious complaints: x21

July 2015:
verbally aggressive: x3
physically aggressive: x1
resist care: x1
repetitive anxious complaints: x10

August 2015:
verbally aggressive: x2
physically aggressive: x0
resist care: x1
repetitive anxious complaints: x2

September 2015:
verbally aggressive: x11
physically aggressive: x3
resist care: x5
repetitive anxious complaints: x11

October 2015:

verbally aggressive: x8
physically aggressive: x0
resist care: x0
repetitive anxious complaints: x19

November 2015:
verbally aggressive: x17
physically aggressive: x1
resist care: x0
repetitive anxious complaints: x15

December 2015:
verbally aggressive: x15
physically aggressive: x4
resist care: x1
repetitive anxious complaints: x18

The written care plan at the time of the incident dated a specific date in July 2015 and the actual care plan dated a specific date in September 2015 were revised by the inspector and it was observed that there was no provision for the physical aggressive behaviours, the identified triggers or interventions in place to mitigate the behaviour. [s. 26. (3) 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A critical incident report was submitted to the Director reporting an incident of staff to resident physical abuse. It was reported that on a specific date in December 2015 during care, PSW #S104 slapped resident #003 hard on a specific body part twice because the resident had pinched and hit the PSW.

During an interview, RN #S103 indicated to Inspector #550 resident #003 is very aggressive physically towards PSWs during care or when they want to remove the resident from a situation/area. When administering medication and providing care, staff need to use a gentle approach. Staff will provide care to the resident when he/she is calm and quiet. Staff are usually able to perform half of the task at a time ie: wash and dress only the bottom part as the resident becomes easily agitated and physically aggressive. They will then stop and attempt to do the upper half at a later time. They are always 2 PSWs to provide care; one to do the care the other to distract.

RN #S102 indicated to the inspector the resident is physically aggressive on a daily basis. Listed interventions in place as 2 staff to provide care; sometimes effective

sometimes not, have the resident's spouse assist when he/she visits and administer PRN medication in the morning for pain as resident #003 has arthritic back pain.

Inspector #550 reviewed the resident's health records and observed documentation as follows:

Flow sheets for resident #003 for three months indicated the resident was physically abusive and resisting care as follows:

In October, 2015:
physically abusive: 38 times
resisting care: 37 times

In November 2015:
physically abusive: 37 times
resisting care: 38x times

In December 2015:
physically abusive: 39 times
resisting care: 46 times

Resident #003 was seen by the Tri-County outreach nurse/team and recommendations were suggested as follows:

On a specific date in November 2015 it was suggested that the resident needs open back tops and staff to follow-up with the resident's spouse, utilize socks on the resident's hands when transferring to prevent the resident from pinching staff, monitoring of pain as a potential source of agitation and consider a specific neuropathic pain medication if trial of a specific antidepressant is not effective.

On a specific date in January 2016: the same recommendation to review need for open back clothes and continue with interventions.

On a specific date in December 2015, there was a note in the resident's health records by the Physician's assistant indicating "Discussed with the physician: if no improvement in another week, go ahead with prescription of a specific neuropathic pain medication with specific dosage instructions. Inspector reviewed the resident's medication administration record as of January 13, 2016 and observed there was no prescription for

the specific neuropathic pain medication.

During an interview, the DOC indicated the home had spoken to the resident's spouse after the suggestion by outreach in November 2015 to have open back clothes and had provided him/her with a catalogue from Sylvert's clothing as he /she had said he/she would purchase some for Christmas. It was reported that the resident's spouse did purchase new tops at Christmas but they were not open back. The DOC indicated the home is now trying to find a seamstress to open the tops for the resident. She indicated the socks on the resident's hands were tried but not effective as the resident was able to remove the socks. She indicated that pain is assessed with the Abbey pain scale in Medecare but it was not done after it was suggested by the outreach team. She further indicated not knowing why the trial of a specific neuropathic pain medication was not started on a specific date in December 2015 as suggested by the Tri-County outreach psycho geriatric team and approved by the physician. She further indicated not all the strategies developed have been implemented, the resident's response to interventions is not documented as well as some of the assessments, reassessments and interventions. [s. 53. (4)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (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:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to 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:

3. Behaviour management.

In accordance with regulation 221. (2) 1., the licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsecetion 76(7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76(7) of the Act.

Residents #002, #003 and #006 were identified as exhibiting responsive behaviours. During an interview, the DOC indicated to Inspector #550 that 75% of their direct care staff received some training in behaviour management in 2015.

As such, 25% of staff who provide direct care to residents did not receive training in behaviour management in 2015. [s. 76. (7) 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was immediately notified upon becoming aware of the alleged, suspected or witness incident of abuse of the resident that resulted in a physical injury or pain to the resident.

A critical incident was submitted to the Director on a specific date in August 2015 reporting an incident of physical abuse between resident #001 and #002 that occurred on another specific date in August 2015.

Inspector #550 reviewed resident #001's health records and was unable to find any documentation that the resident's substitute decision maker (SDM) was informed of the incident. During an interview, the Director of Care indicated to the inspector the resident's SDM was informed as she had indicated on the critical incident report and that it should have been documented in the resident's progress notes when he was notified by the person who notified him but that it was not documented.

Inspector #550 interviewed the resident's substitute decision maker who is also the resident's power of attorney. He confirmed he was the person who is to be notified of any incidents or changes in resident #001's condition and he indicated he was not immediately informed of this incident of physical abuse. He indicated to the inspector he was informed of the incident at an event he attended on a week-end outside the home where he encountered a nurse who works at the home and who during a conversation happened to mention the incident.

As such, the resident's substitute decision maker was not immediately informed of the incident of physical abuse to resident #001 by resident #002. [s. 97. (1) (a)]

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.