Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 28, 2023

Inspection Number: 2023-1237-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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

Long Term Care Home and City: Woodland Villa, Long Sault

Lead Inspector	**Inspector Digital Signature**
Mark McGill (733)	Mark J McGill Digitally signed by Mark J McGill Date: 2023.11.03 09:29:19 -04'00'

Additional Inspector(s)
Jessica Lapensee (133)
Heath Heffernan (622)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27-30, July 4-6, 10-14, 17-18, 2023

The following intakes were inspected:

Intake: #00022862 complaint related to resident care concerns,
Intakes: #00083901, CIR #2743-000009-23, 00085440, CIR #2743-000012-23, #00086972, CIR #2743-000015-23 related to falls prevention and management,
Intake: #00086619, CIR #2743-000014-23 related to alleged neglect,
Intake: #00085681 - Follow-up to CO #001 from report 2022-1237-0002,
Intake: #00085682 – Follow-up to CO #002 from report 2022-1237-0002,
Intake: #00085683 – Follow-up to CO #003 from report 2022-1237-0002,
Intake: #00085684 – Follow-up to CO #004 from report 2022-1237-0002.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1237-0002 related to O. Reg. 79/10, s. 131 (2) inspected by Heath Heffernan (622)

Order #002 from Inspection #2022-1237-0002 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Mark McGill (733)

Order #003 from Inspection #2022-1237-0002 related to O. Reg. 246/22, s. 20 (b) inspected by Jessica Lapensee (133)

Order #004 from Inspection #2022-1237-0002 related to O. Reg. 246/22, s. 268 (4) 1. ix. inspected by Jessica Lapensee (133)

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Safe and Secure Home
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the written plan of care set out direction for a residents' orthopedic device.

Rationale and Summary

A review of a residents' progress notes on Mede care indicated that on a specified date, the resident returned from an appointment with an orthopedic device on a specified body part. Direction for the device included it must be worn and kept dry, it can only be removed during shower and put back after shower.

A review of the resident's current care plan on Mede Care indicated that there was no direction for the orthopedic device.

During interviews on a specified date, with the Inspector, two Personal Support Workers (PSWs) stated that staff would look in the care plan document for direction to care for a resident. The resident's orthopedic device and directions for use were not added to the care plan document and therefore was not providing clear direction to the staff.

By not having clear directions on the plan of care for a resident, increases risk that appropriate care may not be provided.

Sources: A specific **resident's care plan document, progress notes, interview of a PSW and other staff.** [622]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a residents' plan of care set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

During an interview with the Inspector on a specified date, the Administrator indicated that the plan of care encompassed all documents which include the progress notes and the care plan document.

A review of the progress notes indicated that the resident sustained an injury on a specified date. The

Physiotherapist had changed the resident's mobility restraint to a more robust mobility aide restraint on a specified date, and due to declining condition, one week later, the resident required full mechanical assistance for transfers.

A review of the resident's care plan on Mede Care, that was current at the time of the fall on a specified date indicated that the resident always required a mobility aide, extensive assistance for all transfers, however also stated that the resident was independent for walking in the corridor and in their room.

Furthermore, the care plan document was not updated after the resident's incident to include the following interventions until after the resident passed away on a specified date.
- A robust mobility aide restraint updated by the Director of Care three weeks after the resident's death.
- extensive assistance of two staff, using a mobility aide for all transfers including toileting was updated by the Administrator three weeks after the resident's death.

Two PSWs and a Registered Nurse (RN) stated that the resident's plan of care did not offer clear direction to staff who cared for the resident prior to their incident for ambulation, nor after the incident when there was a discrepancy between documentation in the progress notes and the care plan document for the robust mobility aide restraint and the full mechanical assistance for transfers and toileting requirements.

Therefore, by not providing clear direction to the staff who care for a resident at risk of falling, increases the risk of injury to the resident.

Sources: the progress notes, care plan, and interview with a PSW and other staff.
[622]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care has been documented.

Rationale and Summary

A review of a resident's care plan that was current at the time of falling on specified dates, indicated the

resident required extensive assistance from staff for routine toileting.

A review of the Mede Care - Point of Care documentation indicated that there was missing documentation for the resident toileting routine on specified dates.

During an interview with the Administrator, they stated that there was missing documentation for toileting on three separate dates as the internet server was down because of bad weather. Staff were not able to document on Mede Care and there was no back up for staff to document when the internet was down.

Sources: a resident's health records, interview with the DOC and other staff.
[622]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the laundry room door, a non-residential door was kept closed and locked when it was not being supervised by staff.

Rationale and Summary

On a specified date, the inspector observed the main laundry room door propped open with a doorstop. The inspector also noted a sign on the door that read "Please ensure this door is kept closed at all times". When the inspector entered the room, it appeared to be unoccupied. Upon entering the room further, the inspector noticed a chemical storage room on the left-hand side with the door also open. There was also an unlocked door that led to the wing of the home that was under construction. The inspector then exited the room and notified Housekeeping/PSW staff who was passing by in the hallway, that the door was left ajar.

Several minutes later, the inspector returned to the laundry room and spoke with Laundry Staff. The inspector asked if the laundry room door is left ajar often to which they replied - almost daily, in-order to facilitate easier transport between the construction site and the home.

The laundry room is located at the end of the main/administrative hallway adjacent to a resident unit. This resident area is behind a closed door that is opened via swipe card or keypad and it is not a locked

unit. During the course of the inspection, the inspectors observed several residents, some of whom were on their own, traveling up and down the hallway where the laundry room is located.

The Administrator confirmed that the laundry room door is to be kept closed and locked at all times.

The failure to ensure that the laundry room door was kept closed and locked when it were not being supervised by staff, posed a risk to the safety of all residents who use that hallway to travel to and from home areas related to physical injury.

Sources: observations conducted by inspector on a specified date; interviews with staff including housekeeping/PSW staff, Laundry Staff, and the Administrator.

[733]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident fell on a specified date.

A review of the post fall assessment titled: post fall investigations, under the Mede Care assessment tab, indicated that there were no post fall assessments completed on the specified date for the resident's fall.

During an interview with the Inspector, Registered Nurse (RN) reviewed the post fall investigations under the Mede Care assessment tab for the resident and stated that the post fall assessment had not been completed for the fall on the specified date.

There was no known impact to the resident, however the risk to the resident following their fall was moderate as the resident was not assessed post fall to determine if the resident's plan of care required updating to prevent further falls.

Sources: the CIS, progress notes, post fall investigation document, and interview of a Registered Nurse and other staff.
[622]

COMPLIANCE ORDER CO #001 Duty of Licensee to Comply with Plan

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 6 (7).

The licensee shall:

1) Develop and implement a procedure for registered staff to monitor and ensure that on each shift, the direct care staff comply with the written fall prevention plan of care (specifically mobility aide alarms) for two specified residents.

2) A written record must be kept of everything required under 1) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that the care set out a resident's falls prevention plan of care was provided to the resident as specified in the plan.

Rationale and Summary

On a specified date, the Inspector observed the resident's mobility aide at lunch; they did not have a mobility aide alarm in place.

A review of the current plan of care including the Morse Fall scale, the care plan on Mede Care and the logo board in the resident's room indicated that the resident was at high risk for falling and was to have an alarm in place.

During interviews on a specified date with the Inspector, a Registered Nurse and Registered Practical Nurse stated that the resident required a mobility aide alarm in place.

There was moderate risk to the resident as their falls prevention intervention was not in place.

Sources: observation of the resident's fall prevention interventions, the resident's health records including: the care plan, Morse Fall Scale, the logo board, and interview with a Registered Nurse and other staff.
[622]

The licensee has failed to ensure that the care set out in a second resident's fall prevention plan of care was provided to the resident as specified in the plan.

Rationale and Summary

On a specified date, the Inspector observed the resident in their room behind the closed door. The resident was using a mobility aide; there was no alarm on the mobility aide or in their room.

Review of the resident's current plan of care included the Morse Fall Scale assessment that indicated the resident was a high risk for falls and the care plan on Mede Care which indicated that the resident was to have their alarm always activated.

During separate interviews with the Inspector on a specified date, two Personal Support Workers (PSWs) stated that the resident was a high risk for falls and should have had their alarms in place.

The risk the to the resident was high as the falls prevention intervention was not in place while the resident was not in view of staff.

Both of the above resident's had previous falls with injuries.

Sources: Observation of the resident's fall prevention interventions, the resident health records and interview with a PSW and other staff.
[622]

This order must be complied with by October 6, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.