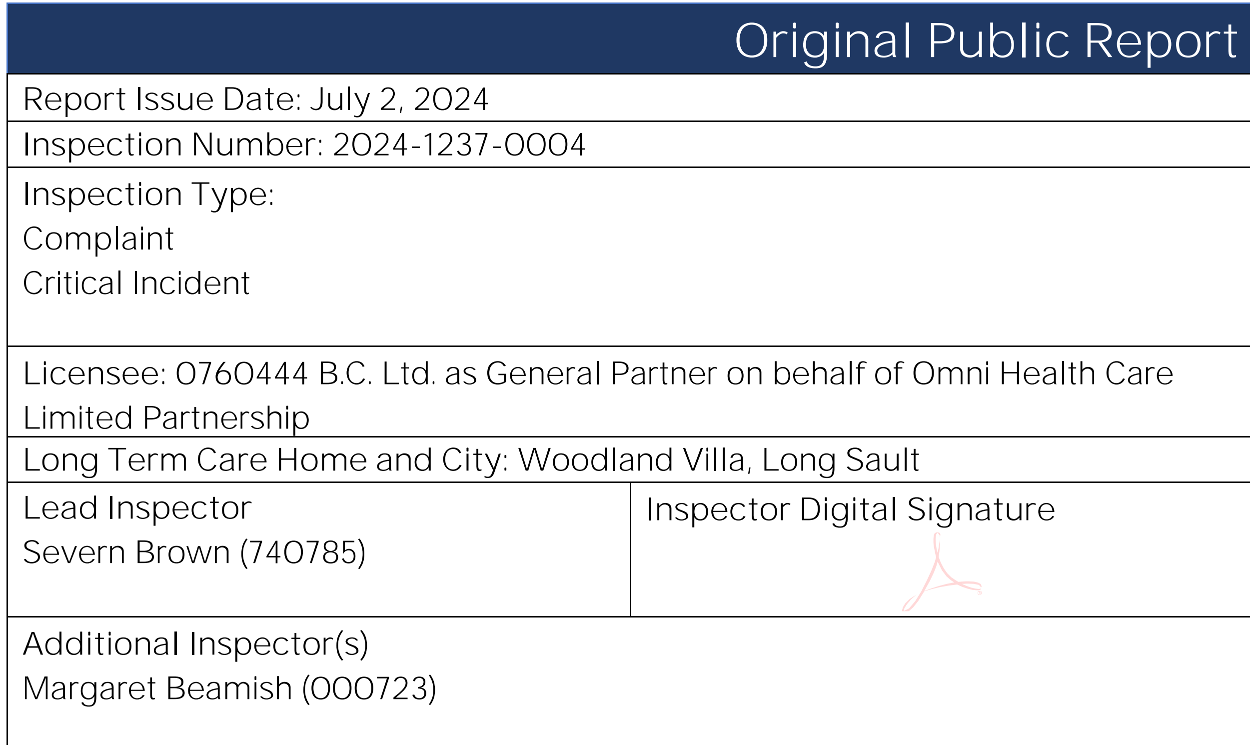
Ontario

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

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

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



Original Public Report	
Report Issue Date: July 2, 2024	
Inspection Number: 2024-1237-0004	
Inspection Type: Complaint Critical Incident	
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 Severn Brown (740785)	Inspector Digital Signature
Additional Inspector(s) Margaret Beamish (000723)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19, 20, 21, 24, 25, 26, 27, 28, 2024 and July 2, 2024

The following intake(s) were inspected:

- Intake: #00115314 -IL-0125830-AH/2743-000023-24 - Resident to resident abuse
- Intake: #00116013-IL-0126182-OT/ IL-0126301-OT -Complaint regarding staffing and resident care
- Intake: #00117376-2743-000025-24 - Resident to resident abuse
- Intake: #00117566-2743-000026-24 - Resident to resident abuse

- Intake: #00117786 -2743-000028-24 - Resident fall with change in condition

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

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) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care provides clear direction to staff. Specifically, a resident's plan of care does not provide clear direction to staff regarding the resident's one-to-one sitter requirement.

Sources:
A resident's care plan and electronic chart;

Interviews with a Personal Support Worker (PSW), two Registered Nurses (RN) , and the Director of Care (DOC).

[740785]

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed at a minimum twice a week by the method of their choice when it was documented that the resident was not bathed on three occasions.

Sources: Documentation survey reports for bathing of a resident, the resident's progress notes; interviews with a Registered Practical Nurse (RPN), a PSW, and the DOC. [000723]

WRITTEN NOTIFICATION: Security of drug supply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. 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.

The licensee has failed to ensure that an area where drugs are stored was kept locked at all times, when not in use.

Sources:
Observation of the medication room on Moulinette Unit.

[740785]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the documentation of the application of a topical prescription medication, which was ordered by a resident's physician, was not completed for almost all of the required entries.

Sources: A resident 's medication administration record, the physician's orders, interviews with an RPN and the DOC. [000723]