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

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Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1237-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 25 - 27, 2025 and March 3 - 6, 2025

The following intakes were completed in this follow-up inspection:
Intake: #00137312 - Follow-up #: 1 - O. Reg. 246/22 - s. 55 (2) (b)

The following complaint intake(s) were inspected:
Intake: #00132684 - Complaint related to the death of resident.
Intake: #00134320 – Complaint related to a resident's medications and improper care.
Intake: #00136690 - Complaint related to potential staff to resident abuse

The following intakes were completed in this Critical Incident (CI) inspection:
Intake: #00133590/CI #2743-000054-24 and #00136546 /CI #2743-000004-25 – related to improper/Incompetent care of resident by staff.
Intake: #00137035/CI #2743-000005-25- related to an allegation of neglect of a resident by staff.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1237-0008 related to O. Reg. 246/22, s. 55 (2) (b)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident. Specifically related to the application of a restraint when the resident is up in their wheelchair to prevent them from falling.

In December 2024, a resident slid from their wheelchair, becoming entrapped by an assistive device. A review of the care plan (revised in November 2024) indicated the use of a restraint and assistive device when the resident is up in their wheelchair to prevent them from falling.

During an interview with the Director of Care (DOC), they indicated after completing an investigation into the incident, they identified the Personal Support Worker (PSW) that was assigned to the resident did not apply the restraint when resident was up in their wheelchair. Only the assistive device was applied.

Sources: Interview with DOC, PSW, a resident's progress notes, and care plan.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that provision of care set out in a resident's plan of care related to the completion of skin and wound treatments were documented on multiple days throughout February 2025.

A review of the electronic treatment record (ETAR) for February 2025 reflected missing documentation on multiple days in February 2025 to validate the completion of four skin and wound care treatments ordered for the resident.

Sources: Interview with the DOCs, February 2025 ETAR documentation.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented. Specifically documenting the turning and re-positioning of the resident every two hours when they are in bed or up in their wheelchair.

A review of the resident's Point of Care (POC) documentation reflected sixty seven missing entries for the month of February 2025.

Sources: Interview with the DOC, February 2025 POC documentation, resident's care plan, Policy OTP-HLHS-3.4 Preventative Skin Care.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when care set out in the plan is no longer necessary, specific to the discontinuation of the use of a assistive device when the resident is up in their wheelchair. During an interview with the DOC, they indicated the use of the assistive device for a resident was discontinued after an incident that occurred in December 2024. A review of the resident's current care plan (last revised in December 2024), continued to reflect the use of the assistive device for the resident.

Sources: observation of the resident, interviews with the DOC, PSWs, care plan (revised December 2024).

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by a Personal Support Worker (PSW).

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Director of Care (DOC) confirmed that a PSW did not provide care to a resident during their shift on a specific day in January 2025.

Sources: Zero Tolerance of Abuse and Neglect to Residents policy (policy: OP-AM-6.9); LTCH investigation notes; interview with a PSW and the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that a Registered Nurse (RN) followed the licensee's policy: OP-AM-6.9 titled: Zero Tolerance of Resident Abuse and Neglect of Residents. The DOC confirmed that the RN did not immediately notify the Home's Administrator or Manager on-call, when they became aware of an allegation of neglect toward a resident by a PSW.

Sources: Zero Tolerance of Abuse and Neglect to Residents policy (policy: OP-AM-6.9); LTCH investigation notes; interview with a PSW, a RN and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that an allegation of neglect by a Personal Support Worker (PSW) toward a resident was immediately reported to the Director. The Critical Incident System (CIS) report was submitted two days after the allegation was reported.

Sources: Critical Incident System report (CIS); LTCH investigation notes; interview with the DOC and a RN.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee has failed to ensure that a physician's order was received prior to the application of a restraint for a resident. Specific to the use of a safety device when the resident is seated in their wheelchair.

Sources: Review of physician's order, Consent to Use of Restraint, interview with the DOC.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are

documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure the monitoring of a physical device to restrain a resident, was documented. Specific to the use of a safety device when the resident is up in their wheelchair.

A review of the resident's Point of Care (POC) documentation reflected seventeen missing entries during the month of December 2024.

Sources: December 2024 POC Documentation survey, Policy CS-5_5_Personal Assistive Safety Device and Restraint Monitoring_Section 5 - Minimizing of Restraints_reviewed_September_20_2022, Interview with the DOC.

WRITTEN NOTIFICATION: Medication management system

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure their written policies and procedures ensure their accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy, Section 8: Transition of Care Care Rx "Medication Reconciliation",

No: 8. 2, Initial Effective Date: July 13, 2022, Revised date: July 31, 2024 indicates the following:

1. Upon the admission of a new resident to the Home, the nurse compiles the best possible medication history (BPMH). This is completed by obtaining a list of current medications from at least two sources. Sources may include: Community pharmacy medication list/profile, Medication vials/supplies brought into the Home upon admission, Medication reconciliation Interview Tool (if used in the information gathering process), Previous Long-Term Care or Retirement Home Medication Administration Record (MAR), Transfer/Discharge Orders, Family Physician, The resident (SDM where applicable) is interviewed as a required source to ensure the complete medication history is obtained.

Specifically, the licensee failed to comply with their medication management system policy and procedures when the Resident Services Coordinator (RSC) only used one source of information when completing the Best Possible Medication History (BPMH) for a resident upon admission, when the Medication Reconciliation Policy requires two sources. The resident experienced adverse health effects shortly after admission. A medication reconciliation was completed and medications ordered approximately three weeks later after the family identified that medications may be missing to the home's staff.

Sources: A resident's Progress Notes, eMAR March 2024, and InterRAI assessment, The Retirement Home MAR, CareRx Policy: Medication Reconciliation, interview with the Resident Services Coordinator.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that the medication cart was locked. In February 2025, a medication cart was observed to be left unattended and unlocked in the hallway on a specific unit.

Sources: Observation.