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**
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# Public Report

**Report Issue Date:** April 28, 2025

**Inspection Number:** 2025-1237-0002

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.

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

## INSPECTION SUMMARY

The inspection occurred on the following date(s): April 4, 7, 8, 9, 10, 14, 15, 16, 17, 22, 23, 2025

The following intake(s) were inspected:

- Intake: #00140462 - related to a resident's fall resulting in a significant change in the resident's condition.
- Intake: #00142629 - related to alleged neglect of a resident and concerns related to medication administration and footcare.
- Intake: #00143356 - complaint with concerns about a resident's care.

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

Continence Care
Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Residents' Rights and Choices

Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Involvement of resident etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care. Specifically, a resident's SDM was not notified about initiation of their isolation precautions.

Sources: Progress notes, Email sent by resident's SDM, DOC's response letter and interview with DOC.

## WRITTEN NOTIFICATION: Documentation

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 the provision of care that was set out in a resident's plan of care was documented. Specifically, the documentation in a resident's Medication Administration Records was missing on specific dates for some of their scheduled medications.

Sources: Medication Administration Records and interview with DOC.

## WRITTEN NOTIFICATION: Continence Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Specifically, a resident who is incontinent did not receive an assessment of incontinence.

Sources: Electronic record review, resident care plan and interview with DOC.