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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2013	2013_200148_0006	O-000022-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 24, 2013 on site

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Registered and non-registered nursing staff and support staff.

During the course of the inspection, the inspector(s) reviewed resident health care records and the home's investigation notes related to the critical incident.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s.6(1)(c), in that the plan of care for an identified resident does not set out clear directions to staff related to the administration of medication.

An identified resident has a physician order for a psychotropic daily at bedtime. The plan of care for Sleep and Rest for this resident indicates that the psychotropic is provided for sleep, should the resident wish it. The Medication Administration Records (MARs) for January 2013 indicates three days in which the administration of this medication was not documented, it could not be confirmed if the medication was given, refused or missed. Interviews with two Registered Practical Nurses, described the medication to be given to the resident when the resident comes to the nursing station to ask for it. If the resident does not come to the nursing station he may not receive the medication. The Director of Care stated that this is a regularly prescribed medication and is to be administered daily. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.30(2) in that hourly monitoring for an identified resident, related to wandering, was not documented.

An identified resident is known to exit seek, is on the wandering list and is to be checked hourly.

On a day in January 2013 the "Wanderer's Location Within the Home" flow sheet for the identified resident, did not indicate any documented hourly checks from 1500 to 2200 hours. A progress note on the same day, states that the resident was found off the unit and a barrier was put up to deter the resident from leaving the unit again.

On a separate day in January 2013 the "Wanderer's Location Within the Home" flow sheet for the identified resident, did not indicate any documented hourly checks from 0700 to 1400 hours. A progress note on the same date states that the resident was found outside of the home without her jacket. [s. 30. (2)]

2. Interviews with several nursing staff in the home, who are responsible for the care of an identified resident, stated that the resident is regularly resistive to care and that the resident is isolated and rarely interacts with other residents or staff members.

On a day in January 2013 the home reported that the identified resident was aggressive with a co-resident. The Mood and Behavioral Observational Flow Sheets have no entries in January 2013. Progress notes for January 2013 do not indicate any of the above reported behaviors or the incident of aggression in January 2013. [s. 30. (2)]

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Issued on this 28th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Amanda Nix RO LTCH Inspector