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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 14, 2016	2016_289550_0028	012244-16	Complaint

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 20, 21, 22, 25, 26 and 27 2016.

This complaint inspection is related to a complaint regarding the care of residents being transferred to hospital following a fall with injury and the administration of medications.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Physiotherapist (PT), the Physiotherapy Assistant (PTA), a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), residents and family members.

In addition, the inspector reviewed resident health care records, policies related to the medication administration and the licensee's fall prevention program. The inspector also observed resident care and services, and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #002 was reassessed and his plan of care was reviewed and revised at least every six months and at any other time when, (c) the care set out in the plan has not been effective.

Resident #002 was admitted to the home in 2016. Upon admission the resident was independent with his/her walker; requiring supervision and oversight from staff. On a specific date the resident sustained a fall with an injury that required him/her to be transferred to the hospital. Upon the resident's return, he/she was no longer able to ambulate on his/her own and was placed in a wheelchair with a seat belt. Resident #002 is cognitively impaired.

Upon a review of resident #002's health care records, the inspector observed that the resident fell 34 times between a specific period of time.

A review of the resident's care plan indicated the resident was at high risk for falls and specific fall prevention interventions were put in place.

During an interview, RN #S100, RPN #S101 and the Physiotherapist (P.T.) indicated to the inspector that despite all the interventions in place and the close monitoring, the resident is still falling. RN #S100 and RPN #S101 both indicated to the inspector the resident is able to loosen the straps of the seat belt and get up. RN #S100 indicated to the inspector she has made a knot on the seat belt strap to prevent the resident from loosening the belt but this was not effective. Both registered staff indicated they don't know what to do with the resident anymore, despite their interventions, he/she keeps on falling. Rn #S100 added that the resident was not assessed by an Occupational Therapist (OT) to investigate further options to prevent him/her from falling as she did not know where to access this service. She later indicated to the inspector, the Physiotherapist had already made an OT referral the day before for the resident.

During an interview, the Physiotherapist indicated to the inspector that he had sent a referral for an OT assessment the day before. When the inspector requested to see the referral, the PT indicated that the activity person was the one who made the referrals and that she was presently on holidays and she would make the referral upon her return from vacation. He confirmed that no referral for an OT assessment was made at this time.

The resident was observed by the inspector many times during this inspection to remove

the seat belt on his/her own.

On a specific date during the inspector's visit, resident #002 fell in the hallway and required to be transferred to the hospital because of an injury. It was observed by the inspector that there were two specific fall prevention equipment in place while sitting in the wheelchair.

The scope and severity of this non-compliance was reviewed. Resident#002 is known to fall frequently and the fact that the licensee did not reassess the resident and review his/her plan of care when the interventions put in place were proven to be ineffective poses a risk of injury to this resident. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when the resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the progress notes indicated that resident #002 had 34 falls during a specific period of time. The inspector observed that no post-fall assessment had been completed by the registered staff after nine specific falls in the resident's electronic records or hard copy record.

During an interview, the DOC and the ADOC indicated that a post-fall assessment instrument is available to staff, titled "Post Fall Assessment" and that this assessment should be completed as per their policy in the electronic records each time a resident has a fall regardless if the fall resulted in an injury or not. The DOC further indicated that there was no documentation in the resident's health care records to indicate that a post-fall assessment had been conducted after each of the nine specific falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

On a specific date while ambulating in the hallway, resident #002 fell and sustained an injury and required to be transferred to the hospital. He/she returned to the home the following day.

During an interview, RN #S100 indicated to the inspector that when resident #002 returned from the hospital, as a result of the injuries, he/she was no longer able to mobilize with his/her walker on his/her own and required to have a wheelchair as primary mode of locomotion. Two specific fall prevention equipment were applied to the wheelchair and another fall prevention equipment was applied to the resident's bed.

During an interview, the ADOC indicated to the inspector that she did not inform the Director of the incident of a specific incident when resident #002 had a fall, was transferred to the hospital and his/her injury caused a significant change to his/her condition. She indicated she did not know she had to report this incident as she did not think there was a significant change in the resident's health condition.

The DOC indicated there was a change in resident #002's condition following his/her return to the hospital and this incident should have been reported to the Director but they forgot. [s. 107. (3.1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols for the medication management system are:
(a) Developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On a specific date, resident #002 was prescribed a specific medication to control a specific behaviour. The medication is dispensed in the form of 1/4 tab of a specific dosage to equal the amount prescribed by the physician, in blister packs.

The documentation in the electronic medication record indicated that the resident was administered the specific medication on specific dates in the form of 1 or 2 tabs.

RN #S100 indicated to the inspector the documentation in the electronic medication administration record is not done properly by all. Some registered staff will document they administered 1 tab to indicate they administered the content of 1 blister of the pack but they should be documenting either 1/4 of a tab or the exact dosage administered.

Upon the request of the home's policy on the documentation of a PRN medication, the Director of care provided the inspector with a document titled ''Documenting a PRN Administration'' from the Med E-Care E-MAR User's manual Page 2-37, 8.0 indicated: Enter the amount to be administered (1.e. 1 tablet = 1). The DOC confirmed that in a situation where the amount to be dispensed is less than 1 tab, the registered staff should enter the dosage.

The Director of Care indicated to the inspector the registered staff are expected to document the dosage they administer as per the home's policy to ensure all are aware of the dosage the resident was given.

As evidenced above, the home's policy on the documentation of PRN medication was not implemented with, whereas the documentation of a PRN medication for resident #002 was not documented as per the home's documentation policy. [s. 114. (3) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On a specific date, resident #002 was prescribed a specific medication twice daily when required for a specific behaviour.

During a review of resident #002's health care records, the inspector observed that there was no documentation of the resident's response and the effectiveness of the specific medication in the electronic medication administration record or the resident's health care records on four specific dates:

The Director of Care indicated to the inspector the effectiveness of a medication administered on a ''as required basis'' is to be documented in the electronic medication administration record or in the progress notes. She further indicated she was unable to find any documentation on the effectiveness of the administration of the specific medication for the above dates. [s. 134. (a)]

Issued on this 19th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2016_289550_0028
Log No. / Registre no:	012244-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 14, 2016
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	WOODLAND VILLA 30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL RASENBERG

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall review and revise resident #002's plan of care to ensure new interventions are explored and put in place to effectively mitigate risks of falls for this resident. The licensee shall involve the resident's substitute decision maker and reach out to external resources, as appropriate.

Grounds / Motifs :

1. 1. The Licensee has failed to ensure that resident #002 was reassessed and his plan of care was reviewed and revised at least every six months and at any other time when,
(c) the care set out in the plan has not been effective.

Resident #002 was admitted to the home in 2016. Upon admission the resident was independent with his/her walker; requiring supervision and oversight from staff. On a specific date the resident sustained a fall with an injury that required him/her to be transferred to the hospital. Upon the resident's return, he/she was no longer able to ambulate on his/her own and was placed in a wheelchair with a seat belt. Resident #002 is cognitively impaired.

Upon a review of resident #002's health care records, the inspector observed that the resident fell 34 times between a specific period of time.

A review of the resident's care plan indicated the resident was at high risk for

falls and specific fall prevention interventions were put in place.

During an interview, RN #S100, RPN #S101 and the Physiotherapist (P.T.) indicated to the inspector that the despite all the interventions in place and the close monitoring, the resident is still falling. RN #S100 and RPN #S101 both indicated to the inspector the resident is able to loosen the straps of the seat belt and get up. RN #S100 indicated to the inspector she has made a knot on the seat belt strap to prevent the resident from loosening the belt but this was not effective. Both registered staff indicated they don't know what to do with the resident anymore, despite their interventions, he/she keeps on falling. RN #S100 added that the resident was not assessed by an Occupational Therapist (OT) to investigate further options to prevent him/her from falling as she did not know where to access this service. She later indicated to the inspector, the Physiotherapist had already made an OT referral the day before for the resident.

During an interview, the Physiotherapist indicated to the inspector that he had sent a referral for an OT assessment the day before. When the inspector requested to see the referral, the PT indicated that the activity person was the one who made the referrals and that she was presently on holidays and she would make the referral upon her return from vacation. He confirmed that no referral for an OT assessment was made at this time.

The resident was observed by the inspector many times during this inspection to remove the seat belt on his/her own.

On a specific date during the inspector's visit, resident #002 fell in the hallway and required to be transferred to the hospital because of an injury. It was observed by the inspector that there were two specific fall prevention equipment in place while sitting in the wheelchair.

The scope and severity of this non-compliance was reviewed. Resident#002 is known to fall frequently and the fact that the licensee did not reassess the resident and review his/her plan of care when the interventions put in place were proven to be ineffective poses a risk of injury to this resident. (550)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

Service Area Office /
Bureau régional de services : Ottawa Service Area Office