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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2018	2018_520622_0023	021521-18	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

HEATH HEFFERNAN (622), AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, 31, 2018 and September 5, 6, 7, 2018.

The following intakes were included in this inspection:
Log #027355-17 (CIS #2743-000019-17), Log #010409-18 (CIS #2743-000010-18), Log #019945-18 (CIS #2743-000015-18) - Falls resulting in injury with significant change in status and hospital transfer.
Log #021075-17 (CIS #2743-000015-17) – Medication Incident.
Log #025514-17 (IL-53969-OT) – complaint related to staffing levels.
Log #001269-18 (IL-55038-OT) – complaint related to falls and care and services.

The following Log #016663-17 (CIS #2743-000012-17) related to a fall resulting in injury with significant change in status and hospital transfer was completed concurrently during this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, the Physician's Assistant, Registered Nurses, Registered Practical Nurses, Registered Dietitian, the Staffing Clerk, Personal Support Workers, Housekeepers, Maintenance staff, the residents and family members.

The inspectors also conducted a tour of the home, observed the administration of medication, reviewed resident health records, medication incident documentation, policies specific to the medication pass, medication administration, medication incident reporting, offensive odours, nutrition and hydration. The inspectors also reviewed meeting minutes for the Professional Advisory Committee, the Family Council, the Residents' Council and the Registered Staff meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provides for a staffing mix that is consistent with residents assessed care needs.

Two anonymous complaints were received by the Ministry of Health and Long-Term Care stating that the staffing levels are low which results in residents not getting their baths.

Inspector #541 reviewed the staffing schedule for a specified month which indicated PSW staffing levels were short on a specified shift nine dates during the month.

Inspector #541 reviewed the flow sheets and bathing schedule for residents #004, 005, 006 and #025 for the specified month and the following was noted:

Resident #005 was scheduled to have a bath twice weekly. The flow sheets indicated resident #005 did not receive a bath as scheduled on the specified date. According to the staffing schedule four PSW positions were short on that specified date and shift.

Resident #004 was scheduled to have a bath twice weekly. The flow sheets indicated resident #004 did not have a bath as scheduled on the specified date.

Resident #006 was scheduled to have a bath twice weekly. The flow sheets indicated the resident did not have a bath as scheduled on the specified date. The staffing schedule for the specified date and shift indicated two PSW positions were short.

Resident #025 was scheduled to have a bath twice weekly. The flow sheets indicated resident #025 did not have a bath as scheduled on the specified date. As noted above, the staffing schedule for the specified date and shift indicated two PSW positions were short.

PSW #122 and PSW #124 were interviewed by Inspector #541 on September 26, 2018 and both PSWs indicated that the PSW staffing level has been short often and baths are not usually completed when working short.

The Administrator indicated that the expectation is that staff provide baths to residents when they are working short, however if this was not possible, extra PSW staff may be called the following day to make up the missed baths. It was noted that residents #004, #005, #006 and #025 did not receive an extra bath when their bath day was missed.

2. On August 31, 2018, the Registered Dietitian was interviewed by Inspector #541. The Registered Dietitian indicated they use the residents' food and fluid flow sheets to assess residents' nutritional status by looking for patterns and comparing food and fluid intake each month.

PSW #104, the Registered Dietitian and the Administrator all indicated during an interview with Inspector #541 that the PSW staff document the food and fluid intake for all residents using Point of Care (POC), an electronic software system. The POC documentation is also referred to as the flow sheets.

Resident #011 was identified at high nutritional risk. Resident #011 had a significant weight loss over a specified three month period.

Inspector #541 reviewed resident #011's flow sheets related to food and fluid intake for a specified month which indicated multiple dates with missing documentation for breakfast, lunch and dinner intake.

Resident #017 was identified at high nutritional risk. Resident #017 had a significant weight loss over a one month period.

Resident #017's flow sheets related to food and fluid intake for the specified month was reviewed and indicated multiple dates with missing documentation for breakfast, lunch and dinner intake.

Resident #019 was identified at high nutritional risk. Resident #019 had a significant weight loss over a one month period.
Resident #019's flow sheets related to food and fluid intake for the specified month was reviewed and indicated multiple dates with missing documentation for breakfast, lunch and dinner intake.

Resident #011, #017 and #019's flow sheet documentation was compared to the staffing schedule to determine if the short staffing coincided with missing documentation. During a specified month, the staffing level was short on four dates which coincided with missing food and fluid documentation.

The Administrator indicated in an interview on August 31, 2018 that they were aware of the missing documentation and attributed the concern to the short staffing which occurred over the summer.

The licensee failed to ensure the staffing plan provided for a staffing mix that ensured residents received two scheduled baths per week and that provided for a staffing mix to ensure the residents flow sheets related to food and fluid intake were completed. [s. 31. (3)]

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 the staffing plan must, (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; (b) set out the organization and scheduling of staff shifts; (c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; (d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and (e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the Medication Incident Report dated a specified date indicated resident #012 was to receive a specified medication during a specified medication pass. On the specified date and time, resident #012's specified medication had been documented that it was administered on the electronic Medication Administration Record (eMAR), however the medication was omitted and remained in the medication cart. There was no ill effect to the resident.

A review of the physician's orders on the hard copy of resident #012's health records indicated that the specified medication was ordered daily at the specified time.

During an interview with inspector #622 on August 31, 2018 at 1110 hours, Director of Care (DOC) #101 stated that the specified medication was not administered to resident #012 on the specified date and time and therefore was not administered to resident #012 as directed by the physician. [s. 131. (2)]

2. A review of the Critical Incident System Report, dated a specified date indicated resident #024's condition had been declining over the previous month. Orders were received for administration of a specified medication q 3 hours when needed. Registered Practical Nurse (RPN) #116 administered a wrong dosage of the specified medication in error. Orders were received from the physician to monitor vital signs Q15 minutes for 2 hours, no ill effect was noted to resident #024.

During a telephone interview with inspector #622 on September 5, 2018 at 1510 hours, RPN #116 stated on a specified date, they read the physician's order wrong and administered the wrong dosage of the specified medication to resident #024.

During an interview with inspector #622 on September 6, 2018 at 1300 hours, Director of Care (DOC) #101 stated that RPN #116 administered a wrong dosage of the specified medication instead of the prescribed amount on the specified date. Furthermore, DOC #101 stated that resident #024 was not administered their specified medication as it had been prescribed.

Therefore the licensee has failed to ensure that drugs were administered to residents #012 and #024 in accordance with the directions for use specified by the prescriber. [s. 131. (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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 26th day of October, 2018

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

Original report signed by the inspector.