Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2019	2019_702197_0023	014726-19, 016576-19	Critical Incident System

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

JESSICA PATTISON (197)

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): September 25-27, 2019

The following logs were inspected as part of this report:

Log 014726-19 - Critical Incident # 2743-000018-19 related to an incident that caused an injury to a resident for which they were taken to hospital and had a significant change in their health status
Log 016576-19 - Critical Incident # 2743-000019-19 related to an alleged resident to resident physical abuse

Inspector, Manon Nighbor (755) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, a Registered Practical Nurse, Personal Support Workers, Physiotherapy staff and residents.

The inspectors also reviewed resident health care records and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan related to falls prevention.

Resident #003 had an unwitnessed fall on a specified date and was sent out to hospital for further assessment. The resident sustained an injury and had surgery prior to returning to the home.

The resident's plan of care in place at the time of the fall indicated that the resident should have a specified intervention in place at all times.

Upon review of the Post-Fall Assessment for resident #003's fall, RN #105 documented the specified intervention was not in place. During an interview with RN #105, they stated they could not recall if the intervention had been in place but that if they documented it wasn't, then that must have been accurate.

Review of the documentation on resident #003's flow sheet for the date of the fall showed no record that the specified intervention had been checked by staff.

Two staff from the physiotherapy department were the first to find the resident after they fell. During an interview, both indicated that they did not recall if the intervention was in place when they found the resident.

PSW #109 indicated to inspectors that they had seen the resident around the nursing desk just before the fall, but could not recall if the intervention was in place at the time. The PSW stated that resident #003's specified intervention was not in place when they went to see the resident post-fall and could not locate it at this time.

PSW #108 stated that just after resident #003 fell, they went down to check on the resident and noticed that the intervention was not in place where is should be and noted that it was elsewhere in the room.

Resident #003's specified intervention was not in place at the time of their fall, as indicated in their plan of care. [755] [s. 6. (7)]

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 care set out in the plan of care for resident #003 is provided to the resident as specified in the plan related to falls prevention, to be implemented voluntarily.

Issued on this 3rd day of October, 2019

[redacted]

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

Original report signed by the inspector.