Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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347 Preston St Suite 420
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347 rue Preston bureau 420
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 1, 2021	2021_548756_0008	020495-20, 004706-21, 004794-21, 004811-21, 004819-21, 005780-21	Complaint

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

LISA CUMMINGS (756)

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): April 1, 6-9, 12-15, 19, 22, 23, 2021.

The following intakes were completed during this Complaint inspection:
- Log #005780-21, regarding testing requirements for support workers and safety of ceiling lifts
- Log #004706-21, regarding response to complaints, care conferences, and infection prevention and control
- Log #020495-20, regarding an allegation of resident abuse
- Log #004794-21, #004811-21, and #004819-21, regarding personal care and bathing

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), an Office Manager, the Life Enrichment Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Activities staff, Housekeeping staff, a screener, and residents.

Also during the course of the inspection, the inspector reviewed resident health care records, admission package documents, written complaints to the home, COVID-19 screening documents, COVID-19 testing documents, an Infection Prevention and Control Plan, and Policy # IF-OM-4.1 Screening and Surveillance Testing, 5, effective March 25, 2021.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

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

5 WN(s)
0 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	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. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to carry out every infection prevention and control measure related to surveillance testing outlined in the Minister's Directive: COVID-19: Long-Term Care Home surveillance testing and access to homes.

During the course of the inspection, two staff members raised concern that construction workers were entering the home without a negative COVID-19 test result. They indicated this concern had been raised with the Administrator and were informed that construction workers were exempt from surveillance testing requirements. A construction worker was then observed working in a resident home area hallway.

The Administrator confirmed that construction workers were exempt from surveillance testing requirements. The screening record for the construction worker did not indicate proof of negative COVID-19 test result and the screener confirmed that construction workers did not require a negative COVID-19 test result to be granted entry the home. In addition, the screener indicated a delivery person entered the home each week and also did not require a COVID-19 test result.

As per the Minister’s Directive, Long-Term Care Homes required all support workers, including delivery persons and maintenance workers, entering the home to have a negative COVID-19 test result before being granted entry to the home. The lack of ensuring support workers entering the home had a negative COVID-19 test result presented an actual risk of exposing the residents to COVID-19.

Sources: Minister's Directive, observations at the entrance of the home, observations on resident home areas, surveillance testing documents, screening documents, interviews with a screener, the Administrator and other staff. [s. 174.1 (3)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the allegation of abuse for a resident was immediately investigated.

A complaint was received alleging that a Staff Member had raised their voice and was rude to a resident. The complaint stated the allegation of abuse was reported to the Administrator twice on the day it occurred. A PSW was witness to this situation and stated the resident expressed that they had been yelled at. The PSW indicated they felt this situation could have been verbal abuse towards the resident.

The Administrator stated they were also witness to this situation and did not feel the activity staff member's behaviour was abuse towards the resident. Despite the complainant and the PSW's suspicion of abuse, an investigation was not immediately initiated.

Sources: Interviews with a PSW, the Administrator and other staff. [s. 23. (1) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the allegation of abuse of a resident was reported to the Director.

A complaint was received alleging that a Staff Member had raised their voice and was rude to a resident. The complaint indicated this allegation of abuse was reported to the Administrator twice on the day it occurred.

The Life Enrichment Coordinator and the Office Manager both recalled this situation being spoken about at the daily morning meeting. The Administrator did not recall this allegation being reported to them or that it was spoken about at the daily manager meeting. The Administrator also stated they were witness to a similar situation and they did not feel this was abuse and therefore they did not report this to the Director.

Sources: Interviews with the Life Enrichment Coordinator, the Office Manager, the Administrator and other staff. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care for the resident.

On admission, the resident's Power of Attorney (POA) was provided a document that stated the date of the admission care conference, however the care conference did not occur. The Power of Attorney inquired about a care conference but the care conference was not scheduled.

Despite the streamlining of requirements for Long-term Care Homes regarding care conferences, the DOC indicated the home was conducting admission care conferences. They were not aware that the resident's POA was provided a date for the care conference and that the care conference had not occurred.

Sources: Streamlining Requirements for Long- Term Care Homes; written communication with licensee and documents provided by POA; resident healthcare record, interviews with the DOC and other staff. [s. 27. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint made to the licensee for the resident received a response within 10 business days.

The resident's POA sent a written complaint to the licensee and had not received a response within 10 business days. The DOC confirmed they had received the written complaint from the POA but the Administrator would be responsible for providing a response.

The Administrator confirmed that the home’s policy is to investigate and respond to complaints within 10 business days. They confirmed that the written complaint was sent to their proper email address but they did not see the email and therefore did not respond.

Sources: copy of written complaint sent from POA to the licensee, interviews with the DOC and Administrator. [s. 101. (1) 1.]

Issued on this 7th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA CUMMINGS (756)
Inspection No. / No de l’inspection :	2021_548756_0008
Log No. / No de registre :	020495-20, 004706-21, 004794-21, 004811-21, 004819-21, 005780-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 1, 2021
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
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 :	Janna Sabourin

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 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. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Order / Ordre :

The licensee must be compliant with s. 174.1 (3) of the LTCHA, 2007.

Specifically, the licensee must ensure that infection prevention and control measures regarding surveillance testing outlined in the current Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes, are complied with.

To that effect, the licensee shall:
a) Ensure that every staff member, caregiver, support worker, and all other persons entering the long-term care home have a negative COVID-19 test result in accordance with the frequency prescribed in the current Minister's Directive: COVID-19: Long-Term Care Home surveillance testing and access to homes.

b) Take immediate corrective action if deviations occur from the established surveillance testing requirements listed in the current Minister's Directive: COVID-19: Long-Term Care Home surveillance testing and access to homes.

c) A written record must be kept of everything required under (a) and (b).

Grounds / Motifs :

1. The licensee has failed to carry out every infection prevention and control measure related to surveillance testing outlined in the Minister's Directive: COVID-19: Long-Term Care Home surveillance testing and access to homes.

During the course of the inspection, two staff members raised concern that construction workers were entering the home without a negative COVID-19 test result. They indicated this concern had been raised with the Administrator and were informed that construction workers were exempt from surveillance testing requirements. A construction worker was then observed working in a resident home area hallway.

The Administrator confirmed that construction workers were exempt from surveillance testing requirements. The screening record for the construction worker did not indicate proof of negative COVID-19 test result and the screener confirmed that construction workers did not require a negative COVID-19 test result to be granted entry the home. In addition, the screener indicated a delivery person entered the home each week and also did not require a COVID-19 test result.

As per the Minister's Directive, Long-Term Care Homes required all support workers, including delivery persons and maintenance workers, entering the home to have a negative COVID-19 test result before being granted entry to the home. The lack of ensuring support workers entering the home had a negative COVID-19 test result presented an actual risk of exposing the residents to COVID-19.

Sources: Minister's Directive, observations at the entrance of the home, observations on resident home areas, surveillance testing documents, screening documents, interviews with a screener, the Administrator and other staff. (756)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 07, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Cummings

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