

**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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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 1, 2021	2021_548756_0010	002856-21	Other

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**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

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**Long-Term Care Home/Foyer de soins de longue durée**

Woodland Villa

30 Milles Roches Road, R.R. #1 Long Sault ON K0C 1P0

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

LISA CUMMINGS (756)

**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct an Other inspection.**

**This inspection was conducted on the following date(s): April 19, 20, 21, 22, 2021.**

**The following intake was completed in this inspection:**

**- Log #002856-21 which was in relation to the use of oxygen therapy**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), a Personal Support Worker (PSW) and residents.**

**During the course of the inspection, the inspector also reviewed resident healthcare records including physician orders for oxygen therapy and careplans, observed resident rooms and oxygen concentrators, and observed the provision of resident care and services.**

**The following Inspection Protocols were used during this inspection:**

**Medication**

**Personal Support Services**

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 oxygen was administered to the resident as per the plan of care.

The resident was prescribed oxygen via nasal prongs for low oxygen saturation. The resident was found to have a low oxygen saturation and oxygen therapy was applied. A Nurse Practitioner and a Physician were later in to assess the resident and found the flow of oxygen from the oxygen concentrator to be set higher than prescribed.

The DOC stated this was investigated and they were unable to determine how the oxygen concentrator was applied at a higher rate than prescribed. They stated the oxygen flow rate was immediately turned down to the prescribed flow rate.

Sources: resident healthcare record, interviews with the DOC and other staff. [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 care is provided as per plan of care, to be implemented voluntarily.***

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**Issued on this 16th day of June, 2021**

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

**Original report signed by the inspector.**