Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 7, 2024

Inspection Number: 2024-1237-0002

Inspection Type:
Complaint
Critical Incident

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

Long Term Care Home and City: Woodland Villa, Long Sault

Lead Inspector	**Inspector Digital Signature**
Saba Wardak (000732)	Saba Wardak Digitally signed by Saba Wardak Date: 2024.05.22 09.09.26 -04'00'

Additional Inspector(s)
Jessica Lapensee (133)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16-18, 22, 23-26, and 29, 2024.

The following intake(s) were inspected:

- Intake: #00105067/ CI #2743-000042-23 - related to ARI - Outbreak declared December 2023
- Intake: #00107579/ CI #2743-000003-24 and Intake: #00111936/ CI #2743-000012-24- related to resident-to-resident physical abuse
- Intake: #00108961 / CI #2743-000006-24 - related to door safety

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The following complaint intake(s) were inspected:

- Intake: #00113302- related to multiple resident rights and resident care concerns

In addition, this inspection included a follow-up to environmental items that were noted on the Phase 1, 2 and 3 Pre-Occupancy Review reports.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Residents' Rights and Choices
Responsive Behaviours
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that provision of care is documented for a resident. Specifically, the licensee has failed to ensure that the nutritional intake of a resident was documented accurately for a specified month.

Rationale and Summary

A review of the resident's Point of Care (POC) task records on Point Click Care (PCC), show that documentation for the resident's nutritional intake for a specified month was not completed on 21 occasions for meals intake. Documentation was not completed on 20 occasions for fluid intake and on 22 occasions for snack intake.

Director of Care (DOC) and Personal Support Worker (PSW) both confirmed that PSW staff are required to complete all documentation related to care and nutritional intake for a resident before the end of their shift. PSW also confirmed that it is not acceptable to leave a care task blank on POC.

Failure to ensure the provision of care set out in the resident's plan of care was documented, placed the resident at risk for decreased ability to effectively monitor the resident's intake and evaluate need for interventions.

Sources: Resident's POC task record documentation, interviews with staff.

[000732]

WRITTEN NOTIFICATION: Weight changes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 2.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
2. A change of 7.5 per cent of body weight, or more, over three months.

The licensee has failed to ensure that a resident was assessed using an interdisciplinary approach, and actions were taken and outcomes were evaluated when they experienced a weight change of more than 7.5% within three months.

Rationale and Summary

A resident's nutritional status was assessed as 'high' upon admission. Upon a reassessment of the resident's weight at a later date, it was revealed that the resident had lost 11.9% of their body weight in less than three months. A weight change progress note was created by the registered dietitian (RD) on the home's electronic documentation system, Point Click Care (PCC), to acknowledge the weight change, however, nutritional interventions were not initiated at the time.

RD confirmed that they failed to include nutritional interventions to the resident's plan of care following their assessment.

A review of the resident's written plan of care also revealed that nutritional interventions were not added to their plan of care at the time of this weight change.

Failing to ensure that action was taken when a resident experienced a weight change of more than 7.5% within three months, placed the resident at a risk of not having their nutritional needs being met.

Sources: Interview with RD, resident's written plan of care, progress notes on PCC, resident's weight summary records on PCC, and Nutrition and Hydration assessments.

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WRITTEN NOTIFICATION: Registered dietitian

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)
Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a registered dietitian (RD) who is a member of the staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary

RD confirmed that they work 149 hours/ month remotely. RD also confirmed that an additional RD is working 15 hours/ month on-site to conduct assessments.

Administrator also confirmed that one of the RDs is working remotely for 149 hours/month and the additional RD is working 15 hours/ month on-site.

At the time of the inspection, the RD was not seen by inspector on-site.

Failure to ensure that an RD was present, on-site for a minimum of 30 minutes per resident per month to carry out their duties, placed the residents at an increased risk for nutritional and other health complications.

Sources: Observations, interviews with staff.

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WRITTEN NOTIFICATION: Packaging of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 135
Packaging of drugs
s. 135. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The licensee has failed to ensure that drugs remain in the original labelled package provided by the pharmacy service provider until administered to a resident or destroyed. Specifically, medications for a resident were left out of package and unattended on the resident's bedside table for a period of time.

Rationale and Summary

A complaint from a resident's substitute decision-maker (SDM) reported that a family member discovered medications in a medicine cup, out of their original packaging, on the resident's bedside table. Family member presented these medications to the Registered Nurse (RN). RN confirmed that these medications belonged to the resident and were scheduled to be administered to the resident earlier in the day.

Failure to ensure that drugs remain in the original labelled package provided by the pharmacy service provider until administered to a resident placed the resident at an increased risk of a medication incident.

Sources: Complaint intake, and interview with RN.

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