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

# Public Report

**Report Issue Date:** June 10, 2025

**Inspection Number:** 2025-1237-0003

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.

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

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27-28, 30, 2025 and June 2-6, 2025

The following intake(s) were inspected:

- Intake: #00143209 - 2743-000015-25 - Fall of resident resulting in injury with change in condition.
- Intake: #00147109 - IL-0140070-OT - Complainant with concerns regarding palliative care for resident

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

Medication Management
Infection Prevention and Control
Palliative Care
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard by the Director with respect to infection prevention and control (IPAC) is implemented. Specifically, the licensee has failed to ensure that section 10.4 (h) of the IPAC Standard for Long-Term Care Homes, that relates to support of hand hygiene of residents prior to any meal or snack, was implemented.

During the inspection a resident was observed coming into the Wales unit dining room for a meal. The resident walked independently to their seat and began consuming the fluids poured for them. The resident was never observed performing or being supported with hand hygiene by the staff in the dining area. The inspector went to the resident and asked if they had washed their hands or anyone had assisted them in performing hand hygiene prior to coming to the dining room, the resident denied being offered hand hygiene.

Sources:
Observation of a resident, during the inspection, at a meal time on Wales unit.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (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 including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint regarding the care of a resident that alleged risk of harm was investigated immediately and responded to within ten business days.

On a specified date, a resident's Substitute Decision Maker (SDM) complained to the Director of Care regarding the resident's care. According to the DOC, there was no formal investigation or response to the complaint.

Sources:
Interview with the DOC.

## COMPLIANCE ORDER CO #001 Palliative care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 61 (1)**
Palliative care
s. 61 (1) Every licensee of a long-term care home shall ensure that a resident's palliative care needs are met in accordance with this section.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

A) Perform a comprehensive review of the home's palliative care program that must include input from management, nursing, medical, dietary, recreational, physiotherapy, and any other relevant disciplines at the discretion of the licensee or its representative. Input on the home's palliative care program must also be received from the home's family and residents' councils.

B) Based on the comprehensive review, develop and implement a written action plan for the assessment of actively dying residents to ensure that symptom management orders are obtained, with appropriate consent, as early as possible before a resident experiences a significant decline in health.

C) Maintain a written record of all meetings related to the review and action plan development including the dates and times of the meetings, the names and roles of the attendees, and the contents of discussion.

D) Educate all active medical and nursing staff in the home on the action plan as well as any other staff members the licensee or its representatives determines relevant. A written record of the education including the date(s) and time(s) of training, the training contents, the name(s) of the trainer(s), and signatures of trainees must be maintained.

**Grounds**

The licensee has failed to ensure that all of a resident's palliative care needs were met in accordance with Ontario Regulation 246/22 s. 61. Specifically, the licensee failed to ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident included symptom management as required by Ontario Regulation 246/22 s. 61 (4) (b).

On a specified date, a resident required multiple medical interventions for

respiratory symptoms. On a later specified date, the resident was diagnosed with a respiratory infection and required supportive medical interventions. During the course of five days, four Registered Practical Nurses (RPN) and fours Registered Nurses (RN) all documented on the resident's declining health and ongoing respiratory symptoms requiring supportive care. Shortly prior to the resident's death, an RN documented that the resident was experiencing significantly worsening respiratory symptoms but were unable to provide comfort care medications to the resident, as ordered by the resident's physician, due to a lack of consent from resident's SDM for treatment.

During their interview, an RN stated that resident was assessed on the shift the resident died and was found to be requiring more supportive medications for symptom management of their worsening respiratory symptoms. The RN further stated they were unable to provide the medications to the resident, as ordered by the resident's physician, as they could not obtain consent from the resident's SDM. During their interview, the resident's SDM stated they would have consented to supportive care medications for the resident's symptoms and wanted the resident to be comfortable but were not provided with the opportunity to consent to these treatments in the days leading up to the resident's death. During their interview, another RN stated that they provided care for the resident in the days leading up to their death and were aware that the resident was actively dying. During their interview the DOC stated they directed the RN caring for the resident prior to their death not to provide the resident with the ordered comfort care medications until appropriate consent could be obtained from the resident's SDM. During their interview, the resident's physician stated they were aware of the resident's poor prognosis and decline five days prior to their death. The physician further stated they were informed of the resident's increased respiratory symptoms during the shift the resident died, however was aware that the RN on duty was unable to obtain consent from the resident's SDM for medications for symptom management. The physician directed the RN on duty not to provide comfort medications without appropriate consent. Per the home's Policy OP-AM-2.3 Palliative Care Program, part

of the program consists of a physical focus on pain management and symptom relief to ensure comfort.

Sources:
A resident's electronic chart and medication administration record;
Interviews with the resident's SDM, two registered nurses, the resident's physician, and the DOC;
Policy OP-AM-2.3 Palliative Care Program.

**This order must be complied with by** August 8, 2025

## COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 102 (8)**
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:
A) Educate a housekeeper, a life enrichment coordinator, and a Personal Support Worker (PSW) on the masking expectations in the home during an outbreak. A written record of the date, time, contents of training, name of trainer, and signature of the trainee must be kept.
B) Perform audits on each unit, at minimum, twice a week, during any outbreak

period prior to compliance due date for staff compliance with masking on all resident care units requiring masking. If staff non-compliance with the home's masking program is identified, immediate correction and re-education must be performed by the auditor.
C) A written record of each audit must be maintained including the name of the auditor(s), the date and time of the audits, the auditing procedure, and if any staff non-compliance was identified requiring staff re-education and correction. The date and time of any re-education, the contents of re-education, and the name(s) and role(s) of the staff members must be recorded on the written audit record.

**Grounds**

The licensee has failed to ensure that all staff participate in the implementation of the home's infection prevention and control (IPAC) program. Specifically, the licensee has failed to ensure that multiple staff members were masked on the unit as required in the home's IPAC program.

During the inspection, a housekeeper was observed in the Wales unit hallway without a mask on. On two occasions during the inspection a staff member was observed without a mask in a resident common area on the Aultsville unit, with a resident present. During the inspection a PSW was observed without a mask in a hallway on the Aultsville unit. The Infection Prevention and Control (IPAC) Lead stated in their interview that all staff are expected to be masked at all times while in any resident areas on the unit during the outbreak.

Sources:
Observations of staff masking on multiple dates;
Interview with the IPAC Lead.

**This order must be complied with by** July 10, 2025

## COMPLIANCE ORDER CO #003 Safe storage of drugs

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:
A) Provide training to all registered nursing staff, including management who can administer medications in the home, on safe storage of medication requirements according to Ontario Regulation 246/22 s. 138 and 139. A written record of the training must be kept detailing the date and time of the training, the training contents, the name of trainer, and the name and signature of the trainee.
B) Audit, for a period of four consecutive weeks on all resident areas in the home, staff compliance with medication cart and prescription topical medication safe storage practices as defined in Ontario Regulation 246/22 s. 138 and 139. At minimum, each resident home area must be audited once weekly, and the audits must include a mix of day, evening, and night shifts. All three shifts are to be audited at least once weekly. If non-compliance with safe storage of medication requirements is determined during any audit, responsible staff members must be provided immediate re-education on medication safe storage practices.
C) A written record must be kept of each audit recording the auditing procedure, the name of the auditor, the date and time of the audit, the determination of staff compliance or non-compliance with medication safe storage requirements, and what corrective action, if necessary, was provided including the name(s) of the re-trained staff members.

**Grounds**

The licensee has failed to ensure that drugs are stored in an area or medication cart that is secured and locked. Specifically, the licensee failed to ensure that medication carts were kept locked at all times when not being directly used and that prescription topical medications were stored in an area that was secured and locked.

During the inspection, the inspector observed the medication cart in the Farrans unit dining area unlocked and unattended while the RPN responsible for the medication cart administered medications to a resident at lunch time. During the inspection, on Farrans unit, prescription topical medications were observed unattended in the unlocked nursing station. During the inspection, in the Aultsville unit dining area, the medication cart was seen unlocked and unattended with a drawer open while the RPN responsible for the medication cart was administering medications to a resident in the dining area at lunch time. During the inspection, an RPN was observed performing the medication pass at breakfast on the Wales unit. The RPN was observed leaving the medication cart unlocked and unattended while administering medications to residents and leaving a medication on top of the medication cart unattended. During the same observation, a resident was observed walking in front of the unlocked and unattended medication cart. During the inspection, a medication cart on the Wales unit was observed unlocked and unmonitored by staff. The RPN responsible for the medication cart was observed in the medication room not observing the cart until the inspector identified the observation with them.

Sources:
Observations of the medication carts during medication passes on Farrans unit, Aultsville unit on and Wales unit during the inspection;
Observation of topical prescription medications on Farrans unit.

**This order must be complied with by** August 8, 2025

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.