Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2013	2013_200148_0015	O-000177-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 11, 2013 on site.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nursing Staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, information related to the critical incident and policies related to the home's Fall Prevention Program.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1) (a), in that the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

An interview with staff member #102, responsible for Resident #001's care, stated that the resident is known to get up from the toilet if left unattended and for this reason must have constant supervision.

The plan of care for Resident #001 does not set out the planned care related to the resident's need for supervision during toileting.

Inspector #148 observed Resident #001 in bed resting during the afternoon of April 11, 2013. Both full side rails were observed to be in the upright position.

Staff interviews confirmed that the resident uses both side rails for safety and positioning.

The plan of care for Resident #001, related to Falls/Balance, indicates that the resident requires only 1 side rail up when in bed.

The current plan of care does not set out the planned care related to the resident's need for side rails. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1) (c), in that the licensee did not ensure that the written plan of care for each resident sets out clear directions to staff who provide direct care to the resident.

The plan of care for Resident #001, related to Transferring, indicates that the resident requires a 3 person transfer for safety.
Interviews conducted with staff members #101 and #102, who were both responsible for Resident #001's care, stated that the resident requires a 2 person transfer.

The most recent Minimum Data Set (MDS) Assessment indicates that Resident #001 requires extensive assistance with one person physical assist for transfers.

The plan of care does not currently set out clear directions for staff related to Resident #001's care needs for transferring. [s. 6. (1) (c)]

3. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (2), in that the licensee did not ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

The plan of care for Resident #001, related to Falls/Balance, indicates that the staff are to reinforce the need to call for assistance and to ensure the call bell is within reach when in bed. Staff interviews confirmed that Resident #001 is not able to use the call bell due to cognitive decline.

The current plan of care intervention related to the use of the call bell for prevention of falls is not based on an assessment of the resident needs and preferences. [s. 6. (2)]

4. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7), in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for Resident #001, related to Falls/Balance, indicates that a laser alarm is to be at bedside to help prevent falls.

Inspector #148 observed Resident #001 in bed resting during the afternoon of April 11, 2013. The laser alarm was not attached to the bedside table and could not be found at any other location in the room.

Staff member #102, who was responsible for the residents care, stated that there was no bed alarm being used for Resident #001.

The issue of the bed alarm was brought forth to the home's Director of Care whom, in the company of Inspector #148, observed the resident in bed resting and discovered the laser alarm was inside the drawer of the resident's bedside table and not in use. [s. 6. (7)]

5. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (8), in that the licensee did not ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Resident #001 fell on two separate occasions, one of the falls resulting in an injury.

The most recent physiotherapy assessment prior to the two falls indicates that Resident #001 is at moderate/high risk of falls.

The Fall Resident Assessment Protocol (RAP) indicates that Resident #001 is at high risk of falls.

The plan of care that was in place at the time of the falls indicates that Resident #001 has Potential/high risk of falls.

The Critical Incident Report submitted to the Director related to the falls indicates that the resident did not have a high risk of falls.

An interview with staff members #101, #102 and #103, responsible for direct care of the resident, did not identify Resident #001 at risk for falls.

Staff who provide direct care to Resident #001 were not kept aware of the contents of the resident's plan of care related to fall risk. [s. 6. (8)]

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 plan of care for Resident #001 clearly reflects the care that is assessed and planned for that resident and that staff are aware of the contents of the plan of care, to be implemented voluntarily.

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Issued on this 19th day of April, 2013

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

Amanda Nee RP LTCH Inspector