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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 22, 2016	2016_258519_0018	031063-16	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF OXFORD
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

WOODINGFORD LODGE - TILLSONBURG
52 VENISON STREET WEST TILLSONBURG ON N4G 1V1

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

SHERRI GROULX (519), ADAM CANN (634), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 14, 15, 16, 17, 18, 21, 2016

The following intake was completed within the Resident Quality Inspection (RQI): #027661-16 (IL-46705-LO) Complaint related to personal care and housekeeping.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Resident Assessment Instrument (RAI) Coordinator, the Supervisor of Food Services, a Dietary Aide, Housekeepers, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Residents' Council and Family Council representatives, residents and families.

The inspectors toured the home, observed meal service, medication passes, a medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) During Stage One observations of the Resident Quality Inspection (RQI), it was noted that there were two half bed rails raised on a resident's bed. This was also observed on a separate date and time.

Upon interview with the resident, the resident stated that they used the bed rails to assist them when they moved around in bed.

A review of the resident's clinical records indicated that the bed rails were being used as a Personal Assistance Services Device (PASD) to assist with the resident's bed mobility. Further record review of the resident's electronic and hard copy file indicated there was no evidence to support that a bed rail risk assessment was completed for the resident.

Upon interview with Administrator/Director of Care, she stated that the home did not have a formal bed rail assessment that was done in the home but that they would assess each resident individually informally and would take off the bed rails if necessary. (634)

B) During Stage One observations of the Resident Quality Inspection (RQI), it was noted that there were two half bed rails raised on a resident's bed. This was observed on several subsequent observations throughout the RQI.

Upon interview with the resident, the resident stated that they used the bed rails to assist them when they moved around in bed.

A documentation review revealed that the bed rails were being used as a Personal Assistance Services Device (PASD) to assist with the resident's bed mobility. Further record review of the resident's electronic and hard copy file indicated there was no evidence to support that a bed rail risk assessment was completed for the resident.

Upon interview with Administrator/Director of Care, she stated that the home did not have a formal bed rail assessment that was done in the home but that they would assess each resident individually informally and would take off the bed rails if necessary. [s. 15. (1) (a)]

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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

Issued on this 22nd day of November, 2016

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

Original report signed by the inspector.