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
Jun 6, 2014	2014_229213_0035	L-000599-14	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

RHONDA KUKOLY (213), JULIE LAMPMAN (522), NUZHAT UDDIN (532)

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): May 26, 27, 28, 30, June 2, 2014

During the course of the inspection, the inspector(s) spoke with the Manager, the Director, the Food Services Supervisor, a Recreation Aide, 2 Registered Nurses, 5 Personal Support Workers, 2 Housekeeping Aides, 1 Dietary Aide, 4 Family Members and 32 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all Resident areas and common areas, observed Residents and the care provided to them. Observed meal and snack service, medication administration and medication storage. Clinical records for identified Residents were reviewed. The Inspectors reviewed policies and procedures, education records, as well as minutes of meetings pertaining to the inspection, observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every Resident is afforded privacy in treatment and in caring for his or her personal needs as evidenced by:
a) On a particular date and time at the end of the Rosewood hallway, a medication cart was observed unattended with the Medication Administration Record (MAR) binder on top.
b) The Manager confirmed that the MAR binder should not have been left unattended as this poses a risk of privacy violation. [s. 3. (1) 8.]

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to the Resident as evidenced by:
a) Interview with Resident #259 revealed that this resident has a specific physical challenge requiring a particular intervention.
b) Review of this Resident's care plan revealed the absence of documentation regarding this challenge or intervention.
c) Interview with Registered Nursing Staff confirmed the absence of documentation in this Resident's plan of care related to this challenge and intervention.
d) Interview with the Manager and Registered Nursing Staff confirmed the expectation that documentation regarding the Resident's physical challenge and the interventions related to this challenge should be included in the Resident's plan of care. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. 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. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a Resident or destroyed as evidenced by:
a) On a particular date, observation of the Cedarcrest medication room revealed that 5 Resident bins within the medication cart were found to have medications that had been removed from their original packaging with the Residents' name and administration directions on them.
b) Interview with Registered Nursing Staff and the Manager confirmed that removing medications from the original packaging was not an acceptable practice. The Manager confirmed the expectation that all medication remain in the original packaging until it is administered to a Resident. [s. 126.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:
a) On a particular date at the end of the Rosewood hallway, a medication cart was observed unattended with a medication prescribed to Resident #308 on top of the cart. The Manager confirmed that the medication should not have been left unattended and unlocked as it is a safety risk. (213)
b) On a particular date in the Cedarcrest dining room Inspector #522 observed Resident #274 remove a medication from a basket on a table in the dining room. Interview with Resident #274 revealed that the nurse leaves the medication in the basket to take. Interview with Registered Nursing Staff confirmed that she had forgotten the medication at the Resident's table after it had been administered to the Resident. The Registered Nursing Staff Member confirmed that this is not best practice and that all medication should be stored and locked on the medication cart. (522) [s. 129. (1) (a)]

Issued on this 6th day of June, 2014

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

Rhonda Kukoly