Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2019	2019_263524_0024	009713-19	Complaint

Licensee/Titulaire de permis

County of Oxford
21 Reeve Street WOODSTOCK ON N4S 7Y3

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

Woodingford Lodge - Ingersoll
325 Thames Street South INGERSOLL ON N5C 2T8

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

INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 17, 2019.

During the course of the inspection, the inspector(s) spoke with the Registered Nurse Manager, a family member and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions and reviewed a resident's clinical records including assessments and care planning interventions.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision-Maker (SDM) had been given an opportunity to participate fully in the development and implementation of resident #001's plan of care.

This inspection was initiated as a result of a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date regarding a room transfer of resident #001 without the Substitute Decision-Maker's (SDM) permission and consent.

During a telephone conversation with resident #001's SDM, they said that the resident was transferred to a different room and they were not aware until after the move. The complainant said they were the Power of Attorney (POA) for care and finances for the resident and they did not provide consent for the transfer. An identified family member had made the request for a room transfer and the home had made the transfer without consulting them. The SDM further stated they were not aware of resident #001's specific responsive behaviours. They said that the home had applied a personal assistance service device (PASD) on the resident and they were not aware of this until after the fact.

The complainant said that at the time of admission, they told the home that if they were unable to reach them, in case of a fall or a health decline they could call an identified family member as an alternative contact.

Review of resident #001's clinical record on PointClickCare (PCC) showed the following:
- the profile page identified the complainant as the POA for personal care and finances.
- the admission progress notes, stated the resident required assistance in decision making and identified that the complainant "has POA for both personal care and property."

- the progress notes on a specific date, documented that the alternative contact was updated of medication changes when in visiting.
- the progress notes on a specific date, noted that a "message left on [alternative contact's] phone regarding the […] room being available and to either come in or call to accept the bed change."
- the progress notes, documented that the alternative contact called and spoke with "myself confirming that […] was agreeable to the room change."
- an internal transfer note on a specific date, stated "this resident transferred to room. All of resident's belongings transferred to […] new room, as per Housekeeping/Maintenance Staff."
- the progress notes, documented that the alternative contact called, was very tearful and had asked if the move had occurred and that the POA was "very upset and was not in agreement with the room change."
- the progress notes on a specific date, documented that the resident was observed with identified responsive behaviours and a PASD was applied. "Note left for staff to update resident's POA tomorrow of the intervention and reasoning for it."
- the progress notes, documented that the resident's POA called back and consented to the PASD. "They had no concerns or questions other than why […] wasn't contacted yesterday when it was applied."

In an interview, Registered Nurse (RN) Manager #101 acknowledged that the POA had not provided consent for resident #001's room transfer and was informed about the PASD after the fact. RN Manager #101 stated they had misunderstood the conversation they had with the POA and their family member at the time of admission. RN Manager #101 said they should have contacted the power of attorney in order to be given the opportunity to participate fully in the development of resident #001's plan of care.

The resident's SDM was not given the opportunity to participate fully in the development and implementation of resident #001's plan of care. [s. 6. (5)]

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.