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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Mar 11, 2014	2014_182128_0003	L-000004-14	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 - INGERSOLL
325 THAMES STREET SOUTH, INGERSOLL, ON, N5C-2T8

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

RUTH HILDEBRAND (128), REBECCA DEWITTE (521)

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): February 18-21 and February 24-28, 2014

During the course of the inspection, the inspector(s) spoke with the Director, Manager of Resident Services, Manager of both the Ingersoll and Tillsonburg sites, Staff Development Coordinator, Secretary, Pharmacist, Nurse Practitioner, RAI Coordinator, 4 Registered Nurses, 1 Registered Practical Nursing Student, Foot Care Nurse, 11 Personal Support Workers, the Supervisor of Environmental Services, 1 Maintenance Worker, 1 Housekeeping Aide, 2 Dietary Supervisors, 2 Dietary Aides, 2 Recreation Aides, 1 Physiotherapy Assistant, 4 Family Members, and 33 Residents.

During the course of the inspection, the inspector(s) conducted a tour of resident areas and common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and the clinical records for identified residents were reviewed. The inspectors reviewed records, policies and procedures, as well as minutes of meetings pertaining to the inspection.

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

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who had reasonable grounds to suspect that any of the following had occurred or may have occurred, did not immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Interviews with three staff (registered and non-registered) confirmed that they were aware of alleged abuse by staff toward residents and did not report it to the Director.
A review of the education records revealed that mandatory abuse education had been completed in 2013 and all the interviewed staff had participated.
The Manager of the home confirmed it was the expectation that all staff immediately report alleged abuse to the Director and to their Supervisor. As soon as she was notified she subsequently took immediate action to submit a Critical Incident to the Ministry. [s. 24. (1)]

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 all staff receive further education so that they are aware that if they have reasonable grounds to suspect abuse of a resident by anyone occurred or may have occurred, they must immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

A clinical record review, for Resident #941, revealed that there was no documented evidence to support that the resident's altered skin integrity had been reassessed at least weekly, although treatments were completed.
In a 3 month period, the assessments were not done at least weekly 5 of 13 weeks (38.5%).
A registered nursing staff member acknowledged awareness that residents exhibiting altered skin integrity needed to be assessed at least weekly and confirmed that the re-assessments had not been done. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

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 has failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

Four pre-poured medications were observed sitting on a dining room table.
This was verified by a Registered Nurse who confirmed that the expectation was that all medications are administered directly to the resident.
The Manager of the home indicated pre-pouring of medications was not an acceptable practice and the expectation was that medications were administered directly to residents. [s. 126.]

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 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, to be implemented voluntarily.

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 has failed to ensure the drugs were stored in an area or medication cart that was secure and locked.

An unlocked and unattended box of prescription treatment creams was observed, February 25, 2014, in the unlocked and unattended nursing station.
A Registered Nursing staff member verified that the nursing station was unlocked and also confirmed that the box of prescription creams was unlocked and unattended. She acknowledged that the expectation was that all medications/prescription creams were to be kept locked. [s. 129. (1) (a)]

2. An unlocked and unattended medication cart was observed, outside a dining room, on February 25, 2014. A Registered Nursing staff member was out of sight of the cart while administering medications to the residents. Other residents were entering the dining room going past the unlocked drug cart.
The Manager of the home indicated that the expectation was that all drugs were to be kept secure and locked while not in view of the Registered Nursing staff. [s. 129. (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 all registered nursing staff receive education related to drugs and prescription creams being stored in an area or medication cart that is kept secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection control program.

On February 20, 2014, a Registered Nursing staff member was observed not washing hands/using hand hygiene between giving residents their medications, in a dining room.
The Registered Nursing staff member acknowledged the lack of hand washing/hand hygiene.
The Manager of the home confirmed that the expectation was to ensure hand hygiene takes place before preparing, handling or serving food or medications to a resident. [s. 229. (4)]

2. A Registered Nursing staff member was observed cleansing the skin of a resident with an alcohol swab during a treatment and then reapplied the used alcohol swab. Another instance was also observed when a Registered Nursing staff member reused an alcohol swab on a resident's skin during an invasive treatment.
Registered Nursing staff members and the Manager of the home confirmed that the expectation was that infection control practices were followed during invasive treatments. [s. 229. (4)]

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 registered nursing staff receive education related to the implementation of the infection control program and specifically in regard to infection control practices surrounding glucose monitoring and insulin administration, as well as hand hygiene during administration of medications, to be implemented voluntarily.

WN #6: 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 has failed to ensure every resident was afforded the right to privacy in treatment and in caring for his or her personal needs.

Resident #001 was observed being provided foot care, in a common area.
The foot care Registered Nurse acknowledged the expectation was that foot care was provided in resident rooms and not in common areas. [s. 3. (1) 8.]

2. The same day, two residents were observed receiving subcutaneous medication, in a dining room, in front of all the other residents.
The Manager of the home indicated that the expectation was that all residents were afforded privacy in treatment, and foot care nor injections should be done in common areas. [s. 3. (1) 8.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, was in compliance with and was implemented in accordance with all applicable requirements under the Act; and was complied with.

A blue bedpan was observed on the bathroom floor, in a resident room, on February 25, 2014. A member of the Registered Nursing staff confirmed that the bed pan was on the floor.
A review of Policy #6.265, entitled Equipment - Bedpan/Urinal, Giving and Removing, dated November 2005, revealed that it was not being complied with. The policy stated "remove bedpan - empty and take to dirty utility."
The Manager acknowledged the expectation was that all policies are complied with and that the bed pan should have been in the dirty utility room. [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that is on at all times and was easily accessed by residents.

The call bells/resident-staff communication and response system, in two resident rooms, could not be accessed by residents as they were observed not functioning, February 19, 2014. Both non-functioning call bells were reported to Personal Support Workers who took immediate action to replace them.
The Director acknowledged that the expectation was that the resident-staff communication and response system was accessible to residents and functioning at all times. [s. 17. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.
Air temperatures, in both dining rooms, on February 25, 2014, were 21 degrees Celsius. This was confirmed by a Personal Support Worker.
A Registered Nursing staff member was aware that the temperature of the dining room was below 22 degrees when residents complained about being cold but no action was taken.
Observations in 7 resident rooms revealed the temperatures were also 21 degrees Celsius. [s. 21.]

2. A maintenance worker adjusted the thermostats and indicated that the building management/heating system had always been set at 21 degrees with the ability for residents to individually increase their rooms to 25 degrees.
The same afternoon at 15:51, a resident room and the front foyer lounge were noted to be at 21 degrees.
A Registered Nursing staff member turned up the thermostats and offered heated blankets to residents in both areas. [s. 21.]

3. The Supervisor of Environmental Services indicated that Control Systems had reprogrammed the building management/heating system, February 26, 2013, so that the minimum temperature was at least 22 degrees everywhere in the home. He acknowledged awareness that the home was to be maintained at a minimum of 22 degrees and indicated that residents would still have the option of increasing the temperature. [s. 21.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

The home does not have a Family Council.
There was no documented evidence to support that the home convened semi-annual meetings, in 2013, to promote the right to establish a Family Council.
The Manager indicated that the home only had one meeting in November 2013 to advise of the right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 12th day of March, 2014

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

RUTH HILDEBRAND