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
Jul 14, 2014	2014_260521_0031	L-000306-14 L-000307-14	Critical Incident System

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

REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 10, 2014

During the course of the inspection, the inspector(s) spoke with the Human Resource Manager, 1 Registered Nurse, 3 Residents and 2 Personal Support Workers

During the course of the inspection, the inspector(s) conducted a facility tour of resident common areas and rooms, reviewed three clinical records and made observations on resident behaviours

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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 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.

An unlocked and unattended box of prescription treatment creams was observed at 11:30 hour on July 10, 2014, in the unlocked and unattended Oakdale nursing station.

An unlocked and unattended box of prescription treatments creams was also observed at 11:40 hour on July 10, 2014 in the unlocked and unattended Cherryhill nursing station.

A staff member verified the nursing stations were unlocked and also confirmed that the boxes of prescription creams were unlocked and unattended. [s. 129. (1) (a) (ii)]

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 #2: 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 failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

On July 10, 2014 at 11:00 hours, 13:30 hours and 15:00 hours it was observed that the Resident Chapel temperature was 21 degrees Celsius.
This was reported to the manager on site. [s. 21.]

Issued on this 14th day of July, 2014

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