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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2015	2015_229213_0021	012182-15	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 - WOODSTOCK
300 Juliana Drive
WOODSTOCK ON N4V 0A1

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

RHONDA KUKOLY (213)

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): June 18, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Resident Care Coordinator, a Nurse Practitioner, two Personal Support Workers, and a Resident.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision and outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

Record review for Resident #001 revealed pain assessments ordered to be completed three times daily for a one week period were not documented as completed on 7/21 occasions and treatments in the months of May and June, 2015 were not documented as being completed on 49/210 occasions.

Staff interview with a Resident Care Coordinator and the Director of Care confirmed that the pain assessments and treatments were not documented as being completed on every occasion and that the home's expectation is that all care set out in the plan of care should be documented. [s. 6. (9)]

2. The licensee has failed to ensure that the Resident was reassessed and the plan of care reviewed and revised when the Resident's care needs change or care set out in the plan is no longer necessary.

Record review revealed that Resident #001 had ongoing pain and a subsequent change in pain medication ordered. Pain assessments were not completed after this change in pain medication.

Record review also revealed that this Resident suffered an injury that would be considered painful and pain assessments were not completed after this injury.

Staff interview with the Resident Care Coordinator and the Director of Care confirmed that pain assessments were not completed after Resident #001 suffered an injury or after an increase in pain medication. They also confirmed the expectation of the home that pain assessments should be completed after a change in a Resident that would affect their pain. [s. 6. (10) (b)]

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 the provision and outcomes of the care set out in the plan of care and the effectiveness of the plan of care are documented. Also, to ensure that the Residents are reassessed and the plan of care reviewed and revised when the Resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 26th day of June, 2015

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

Original report signed by the inspector.