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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2017	2017_606563_0020	024094-17	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 - WOODSTOCK
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

MELANIE NORTHEY (563), INA REYNOLDS (524), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 30, 31, November 1, 2, 3 and 6, 2017

The following intakes were completed within the RQI:
Log #020649-1 - Critical Incident #M632-000019-17 related to falls
Log #019687-17 - Critical Incident #M632-000018-17 related to falls
Log #016657-16 - Complaint IL-44875-16-LO related to resident to resident suspected abuse
Log #015977-16 - Complaint IL-44780-16-LO related to resident to resident suspected abuse
Log #010331-17 - Complaint IL-51021-LO related to staff to resident suspected abuse
Log #020203-17 - Complaint - Minister's Correspondence #HLTC2966MC-2017-7047 related to medications

During the course of the inspection, the inspector(s) spoke with Director, the Director of Care, Resident Service Manager, Staff Development Coordinator, Resident Care Coordinators, Registered Nurses, Registered Practical Nurses, Assistant of Nutritional Services, Personal Support Workers, Occupational Therapist, Rehabilitation Group, Pharmacist, Housekeeping Staff, Family, Secretary, Residents' Council Representatives and over thirty residents.

Inspectors also toured the resident home areas and common areas, medication rooms, observed resident care provision, resident/staff interactions, dining services, medication
administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **4 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 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.

Ontario Regulation 79/10, s. 114 (2) states, "the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

The Long-Term Care Homes Act, 2007, O. Reg. 79/10, s. 135 (1) states, "Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider."

Record review of the Woodingford "Documentation & Reporting Medication Errors & Adverse Reactions" policy # 6.640 last revised March 2, 2015, stated when any medication error has been discovered, it was to be documented on the Medication Incident Form and faxed to pharmacy. The policy also stated, "When any administration medication error has occurred, the registered nurse will review the error, discuss with the pharmacist and notify the physician when a risk is identified. The event is to be documented on the resident record. Where a moderate to high risk is identified, disclosure to the resident and Power of Attorney (POA) personal care is important. Completed medication incident reports are forwarded to the Manager/Assistant Manager of Resident Services. The Manager/Assistant Manager of Resident Services at his/her discretion will contact the pharmacist with any concerns that should not wait to the regular review meeting."

The Resident Services Manager (RSM) acknowledged the Woodingford Lodge "Documentation & Reporting Medication Errors & Adverse Reactions" policy #6.640 needed to be updated. The RSM verified that the policy was not implemented in accordance with all applicable requirements under the Act. The home's policy directed staff to report any administration medication error to the physician when risk was identified. The physician was to be notified of all medication incidents. Also, the resident and or POA are to be notified of all medication incidents, not just medication incidents

where moderate to high risk was identified.

The licensee has failed ensure that the Woodingford Lodge policy related to medication incidents was in compliance with and was implemented in accordance with all applicable requirements under the Act.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living was included in the resident's plan of care.

A resident was observed with a PASD in use. There was no documentation related to interventions for the use of the specific PASD as part of the resident's current care plan

Point Click Care (PCC).

The Resident Care Coordinator (RCC) shared that consent was required for the use of any PASD with documentation related to the reason for the device, and that the there was no consent for the use the resident's specific PASD.

Review of the most recent completed "Interdisciplinary Assessment for the Use of a PASD" in PCC documented the use of a specific PASD.

Record review of the “Restraints Minimization: Use of Personal Assistance Service Devices (PASD) policy number XI I – G – 10.34, last revised May 19, 2017, stated the care plan must outline how the specific PASD was to be used, a timeframe for its use and the care plan must be communicated to all staff and followed consistently. The residents care play must indicate how, when and why the device was to be used as a support to promote independence and quality-of-life. The use of the PASD must be approved by a physician, a Registered Nurse (RN) in the extended class, a RN, a Registered Practical Nurse, Occupational Therapist, or a Physiotherapist. The approving clinician was required to obtain informed consent. Documentation of a PASD must include authorization of the use of the device, care plan to indicate intent as a PASD, progress toward stated goal and monitoring and evaluation of the PASD.

The RCC acknowledged that resident used a PASD. The RCC verified that the use of the specific PASD was absent from the care plan. The RCC also acknowledged that there was no clinical record documentation related to the use of the specific PASD in the progress notes, in the kardex, in the Point of Care (POC) tasks for monitoring, or as part of the PASD assessment completed.

The licensee has failed to ensure that the use of a specific PASD to assist the resident with a routine activity of living was included in the resident’s plan of care.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 33. (3)]

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 use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in the residents' plan of care, 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 labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The Inspector observed a medication cart with a Registered Practical Nurse (RPN) present. The following resident medications were not in the original labelled container as packaged by the pharmacy service provider or the Government of Ontario:
- Medication patches,
- Medication capsule packages,
- Medication pen, and
- Medication tablets were observed in a Culture & Sensitivity (C&S) container, outside the original government stock bottle.

The RPN verified these medications were not in their original labelled packaging from the pharmacy and shared that the original bottle of tablets was in the bottom drawer of the medication cart.

The Inspector observed another medication cart with three RPNs present. Several packages of medication capsules were in the medication compartment dedicated to a specific resident and were outside of the original labelled container provided by the

pharmacy. All three RPNs acknowledged that the capsules were not stored in the original labelled package from pharmacy.

The Inspector observed another medication cart with an RPN present. The following resident medications were not in the original labelled container as packaged by the pharmacy service provider or the Government of Ontario:
- Medication tablets had the expiry date crossed out and a hand written expiry date of August 2019,
- Medication tablets had the expiry date crossed out and a blurred hand written expiry date of May 2018, and
- Medication patches.
The RPN acknowledged that the patches did not remain in original labelled package from pharmacy and shared that there were two larger bottle of government stock tablets used to pour the medications into a smaller bottle for the medication cart.

The Inspector observed another medication cart with a RPN present. The following resident medications were not in the original labelled container as packaged by the pharmacy service provider or the Government of Ontario:
- Medication bottle had an expiry date crossed out and a hand written expiry date of May 2018,
- Medication patches,
- Medication pouches, and
- Medication capsule packages.
The RPN verified these medications were not in their original labelled packaging from the pharmacy.

The Inspector observed another medication cart with a RPN present. The following resident medications were not in the original labelled container as packaged by the pharmacy service provider or the Government of Ontario:
- Medication capsule packages, and
- Multiple medication pens.
The RPN verified these medications were not in their original labelled packaging from the pharmacy, and that the original insulin package was kept in the refrigerator.

The Inspector observed another medication cart with a RPN present. The following resident medications were not in the original labelled container as packaged by the pharmacy service provider or the Government of Ontario:
- Medication bottle had the expiry date "08-2017" and the bottle was full. The RPN

shared that it was filled using stock from a larger bottle that was not expired,
- Medication patches, and
- Medication solution.
The RPN verified these medications were not in their original labelled packaging from the pharmacy, original packages were kept in the cupboard in the medication room.

Record review of the Woodingford “Drug Dispensing and Administration” policy # 6.650, last revised March 2017, stated medications to be administered should be correctly labelled with the prescription number, prescriber's name, drug name, strength, dosage, route and any directions/precautions for use including the expiry date if appropriate. The resident's name and drug store identification should also be clear on the label and Government stocked drugs will be dispensed from a single stock bottle for each drug required for residents on the unit.

The Director acknowledged that this practice did not meet the legislation related to original labelled government stock medications.

The Resident Service Manager and the Pharmacist acknowledged that all medications were to be labelled and to remain in the original labelled container or a package from pharmacy.

The licensee has failed to ensure that drugs remained in the original labelled container or package provided by iPharm Pharmacy or the Government of Ontario until administered to a resident or destroyed.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [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 labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the every medication incident involving a resident

and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

There was a review of the Medication Incident Reports (MIR) binder for MIR completed over a six month period of time in 2017.

The Resident Care Coordinator (RCC) shared that it was the home's expectation that a medication incident report was completed by the staff who identified the error and that same person would fax the incident to pharmacy at the time of discovery. The RCC acknowledged that this was the home's expectation.

The Registered Practical Nurse (RPN) shared that the RPN who discovered an error was also the staff member who then started the medication incident report, faxed it to pharmacy and passed it to the Registered Nurse in charge or the RCC. the RPN acknowledged that the resident, the SDM, the physician, the pharmacy, and the RCC were to be notified of all medication incidents.

The Resident Service Manager (RSM) verified that the RN or RPN that discovered the medication error was the one who filled out the medication incident report (MIR) and faxed it to pharmacy, notified the family, notified the RN in charge and then it's left with the Resident Care Coordinator to review and follow up with the registered staff member involved. The RSM shared that the expectation was for the RCC to check the form for completion and to ensure that the appropriate persons have been notified. The RSM acknowledged that there were multiple medication incident reports that were not reported to pharmacy and the expectation was that all medication incidents were reported to Pharmacy.

Record review of the Woodingford "Documentation & Reporting Medication Errors & Adverse Reactions" policy # 6.640, last revised March 2, 2015, stated when any medication error has been discovered, it was to be documented on the Medication Incident Form and faxed to pharmacy.

Record review of the iPharm "Medication Incident/Near Incident Program" policy #6–001 stated all medication errors will be reported to the resident, resident substitute decision-maker, Pharmacy, Medical Director, Prescriber and the Director of Nursing and Personal Care immediately.

Review of the Medication Incident Reports binder with the Pharmacist noted there were 20 medication incident reports not reported to iPharm Pharmacy in 2017.

The Pharmacist shared that all incidents should have a red stamped "faxed", the incident should be numbered and the pharmacist signature should be present and acknowledged that there were multiple MIRs not faxed to pharmacy. The Pharmacist acknowledged that regardless of the type of medication incident, all were to be faxed to pharmacy and for all the medication incident reports that did not have a faxed stamp or number, the reports were not faxed to pharmacy.

The licensee has failed to ensure the every medication incident involving a resident and every adverse drug reaction was reported to the pharmacy service provider. [s. 135. (1) (b)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The Pharmacist verified that the Professional Advisory Committee (PAC) meeting included a review of two months of medication incident reports only. The Pharmacist acknowledged that as part of the pharmacy report for the PAC meeting the year to date medication incidents were documented incorrectly indicating that there were only eight when there were actually over 20 medication incident reports for that time frame. The Pharmacist verified that for all the medication incident reports that did not have a faxed stamp or number that those reports were not faxed to pharmacy and therefore were not a part of the quarterly review at PAC meetings. The Pharmacist also verified that not all actions and changes implemented were recorded as part of the minutes for the PAC meeting.

Record review of the iPharm "Medication Incident/Near Incident Program" policy #6–001, stated the Medication Incident/Near Incidents will be examined, summarized and analyzed on a quarterly basis and recommendations for policy changes to prevent future errors will be made and implemented as needed.

Review of the Medication Incident Reports binder with the Pharmacist noted there were

multiple medication incident reports were not faxed to pharmacy.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 135. (3)]

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 the every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; and to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home were kept at the home.

A resident was observed with a personal device in use. There was no assessment or documentation as part of resident's clinical record related to the use of the personal device.

The Resident Care Coordinator (RCC) shared that the use of the device was not a part of the plan of care, no Personal Assistance Services Device (PASD) assessment was completed, no Occupational Therapy (OT) assessment was completed, there was no consent, no monitoring in Point of Care and there were no care plan interventions in place. The RCC stated assessments were kept in the OT binder and that the OT takes the binder out of the home.

The Owner/Operator of Arvan Rehab Group and the Director of Arvan Rehab Group verified that they had spoken to the OT and that the OT had the binder outside of the home. They acknowledged that the assessments were a part of the clinical record in the home and were not to be removed. The Owner/Operator verified that clinical records needed to be retained in the home; this included billing records, consents, assessments, Assistive Devices Program (ADP) forms etc. The OT would be returning the binder and that it needed to be kept in a locked location to protect the privacy of the resident's information. The Director of Arvan shared that a formal paper assessment was to be completed and transposed directly in Point Click Care (PCC) as a single point of repository of that information as part of the clinical record. The expectation was that any OT assessment completed was retained in the home as part of the clinical record for any resident seen by the OT.

The Occupational Therapist (OT) verified that their professional progress notes, letters of consent to select a vendor and provide services, wheelchair assessment data sheets, ADP Applications, vendor price quotes, Community Care Access Centre (CCAC) services referral forms, and emails from the nursing home staff related to requests for devices was in the OT binder. The OT acknowledged that all professional progress notes done by hand as part of the residents file in the OT binder needed to be transcribed into PCC under the Occupational Therapy Note and verified that this was not done for each professional note documented by hand on paper. The OT acknowledged that they did remove the binder from the home and that the original assessments, applications, quotes and progress notes were not kept in the home as part of the resident's clinical record.

The Resident Service Manager shared that it was the home's expectation that all assessments and clinical documentation completed related to a resident in the home,

remained in the home.

The licensee has failed to ensure that the Occupational Therapy assessments of the residents of the home were kept at the home.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 232.]

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.