Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 5, 2020	2020_648741_0014	014684-20, 018888-20	Critical Incident System

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 - Woodstock
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

AYESHA SARATHY (741)

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): September 28, 29, and 30, 2020

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

CIS #M632-000029-20 related to falls prevention and management
CIS #M632-000032-20 related to hospitalization and significant change in condition

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Resident Care Coordinator (RCC), the Manager of Resident Care (MRC) and two residents.

The Inspector also reviewed resident clinical records and observed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff related to their care needs and interventions.

A resident's care needs were assessed and changed from requiring minimal assistance for care to requiring extensive assistance after they sustained an injury. In addition, new interventions were implemented for the resident.

The changes to the resident’s care needs and interventions were reflected in the care guide in the resident's bathroom cupboard but not reflected in the resident's Care Plan and Kardex in Point Click Care (PCC). The new interventions in place for the resident were also not included in the Task list in Point of Care (POC) for documentation by Personal Support Worker (PSW) staff.

A Personal Support Worker (PSW) said that they used the care guides in residents’ bathrooms as well as the Kardex to guide the provision of care and expected both documents to compliment each other. They said that the resident’s Kardex contained inaccurate information about their care needs and did not include the new interventions implemented approximately six days prior. The Manager of Resident Care (MRC) said that the resident’s Kardex and POC Tasks should have been updated by registered staff at the time the new interventions were implemented to ensure that staff had clear directions when providing care to the resident.

There was a risk of harm to the resident as a result of staff being provided with unclear direction about the resident’s care.

Sources: the resident’s care plan, Kardex, POC, progress notes, care guide, a Physiotherapy Assessment, a Lift and Transfer Assessment, observations of the resident, and interviews with the PSW, MRC and other staff.

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of their Personal Assistance Services Device (PASD).

During this inspection, a resident was observed on multiple occasions using a PASD. The resident's plan of care did not include an interdisciplinary assessment for the PASD, an order for its use, documented informed consent, and it was not included in the Kardex or on the Point of Care (POC) Task list for documentation by Personal Support Worker (PSW) staff.

A Registered Practical Nurse (RPN) said that the resident began using the PASD approximately six days back. A PSW said that they were required to document on PASDs every shift on POC, and upon review of POC they said the resident's PASD was not included in their Kardex and that PSW staff had not been documenting on it since it was implemented. A Resident Care Coordinator (RCC) said that an interdisciplinary assessment was not completed for the resident's PASD, informed consent was not documented, the care plan and Kardex were not updated and it was not added to the tasks on POC for staff to document on and that each of those steps were required to be completed prior to its implementation.

There was a risk of harm to the resident as a result of implementing their PASD without an interdisciplinary assessment.

Sources: the resident's care plan, Kardex, POC, progress notes, orders, observations of the resident and interviews with the PSW, RPN, RCC and other staff.

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 a plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions with respect to the resident, to be implemented voluntarily.

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.