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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2017	2017_605213_0029	027008-17	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 - TILLSONBURG
52 VENISON STREET WEST TILLSONBURG ON N4G 1V1

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

RHONDA KUKOLY (213), INA REYNOLDS (524)

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): December 4, 5, 6, 7, 2017

During the course of the inspection, the inspector(s) spoke with the Manager, a Nurse Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aides, an Administrative Assistant, a Residents' Council representative, residents and family members.

The inspectors also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of required information and inspection reports and the general maintenance, cleanliness and condition 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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, reported to the resident or the resident's substitute decision-maker, and the resident's attending physician, and corrective actions taken as necessary, with a record kept.

Medication incidents in the home were reviewed for a three month time period.

a) A medication incident occurred on an identified date related to a missed dose of medication for an identified resident. The medication incident report indicated "Resident/Substitute Decision Maker (SDM) notified: no" and "Practitioner Contacted: no" and there was no documentation in the resident's health record or physician communication book that the resident, SDM or physician were notified of the incident. There was also no documentation of follow up to the incident and the staff involved, related to why the medication was not administered, or actions taken to prevent re-occurrence. In an interview with the Manager, they said that they could not recall if the resident's SDM or physician were notified or if there was any follow up with the staff who committed the error. The Manager agreed that these things were not documented and should have been.

b) A medication incident occurred on an identified date related to an identified resident not receiving the full dose of a medication. The medication incident report indicated "Practitioner Contacted:" was blank and there was no documentation in the resident's health record or physician communication book that the physician was notified of the incident. There was also no documentation of follow up to the incident with the staff involved, related the proper procedure or best practice for administering the medication, or actions taken to prevent re-occurrence. In an interview with the Manager, they said that they could not recall if the physician was notified or if there was any follow up with the staff who committed the error. The Manager agreed that these things were not documented and should have been.

c) A medication incident occurred on an identified date related to a controlled substance medication belonging to an identified resident, was found on top of the medication cart and staff were unsure which dose had been missed. The medication incident report indicated "Practitioner Contacted:" was blank and there was no documentation in the resident's health record or physician communication book that the physician was notified of the incident. There was also no documentation of assessment of the resident to ensure the health of the resident after missing this dose of medication. In addition, there was no documentation of follow up to the incident with the staff involved, related how or why the dose was missed and left on top of the medication cart, or actions taken to prevent re-occurrence. In an interview with the Manager, they said that they could not recall if the physician was notified, if the resident was assessed, or if there was any follow up with the staff who committed the error. The Manager agreed that these things were not documented and should have been.

The licensee has failed to ensure that medication incidents involving three residents, were documented, together with a record of the immediate actions taken to assess and maintain the resident's health, reported to the resident or the resident’s substitute decision-maker, and the resident’s attending physician, as well as corrective actions taken as necessary.

The severity of this non-compliance was determined to be minimum risk and the scope was widespread. The home does not have a history of non-compliance in this subsection of the legislation in the past three years. [s. 135.]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.