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
Direction de l'amélioration de la performance et de la conformité

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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
Apr 22, 2013	2013_182128_0008	L-000163-13	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF OXFORD
325 Thames Street South, INGERSOLL, ON, N5C-2T8

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

RUTH HILDEBRAND (128), CAROLE ALEXANDER (112)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 21, 22, 25, 26, 27, and April 2, 3, 4, 5, 8, and 9, 2013

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Services, Assistant Manager of Operations/Resident Care/Infection Control Officer, Staff Development Coordinator, Secretary, Pharmacist, RAI Coordinator, Nurse Practitioner, 4 Registered Nurses, 11 Personal Support Workers, Environmental Services Supervisor, 2 Maintenance Workers, 2 Housekeeping Aides, Registered Dietitian, 2 Dietary Supervisors, 2 Dietary Aides, Kinesiologist, 4 Family Members, 34 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and the clinical records for identified residents were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures, as well as minutes of meetings pertaining to the inspection.

A Critical Incident inspection, related to # L-000091-13, was also completed during this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. A review of the quality improvement program and policies and procedures revealed that the home was unable to demonstrate that the following interdisciplinary programs are fully developed and implemented in the home:
1. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
2. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
3. A pain management program to identify pain in residents and manage pain.

There was no documented evidence to support that there are written descriptions for each of the three required programs that include:
* goals and objectives;
* relevant policies, procedures, and protocols;
* methods to reduce risk and monitor outcomes; and
* protocols for referral of residents to specialized resources where required
The Nurse Practitioner confirmed that the home was in the midst of setting up a pain management program and indicated that when the program is implemented it will provide an opportunity for further education related to pain.
The Assistant Manager of Operations/Resident Care confirmed the home is working on continence care and bowel management, skin and wound care and pain management programs but they have not been fully developed and implemented yet. (112) [s. 30. (1) 1.]

2. Additionally, there was no evidence to support that there are screening protocols and assessment and reassessment instruments in place for each of the three required programs noted above, as evidenced by:
1. A clinical record review revealed that an identified resident has not had a pain assessment done using a clinically appropriate assessment instrument specifically designed to assess pain.
A Registered Nurse confirmed that a Pain Flow record was initiated, for this resident, after the MOHLTC inspectors identified the need for pain assessment/evaluation during this inspection.

2. A clinical record review revealed that an identified resident has not had a pain assessment done using a clinically appropriate assessment instrument specifically designed to assess pain.

A Registered Nurse stated that the home does not have a pain assessment tool but a pain management program is in the process of being developed.
The Nurse Practitioner indicated that although the home does have pain assessment tools, she recognized that they are not always utilized. [s. 30. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. Infection Control Policy # 6.40, dated March 14, 2013, states "personal care supplies are not shared, are kept clean and must be identified with each resident's name, and kept within their living space or in a designated and labelled shelf".
Two Personal Support Workers were not aware of policy expectations related to storage of personal care equipment and stated that the expectation was that urinals were rinsed out, stored on backs of toilets and then changed every shift.
The Infection Control officer confirmed the policy was not complied with related to unlabelled and improperly stored personal care items, including denture cups, urinals and a bedpan. [s. 8. (1)]

2. A Pharmacy Aide was observed alone, in the medication room. A Registered Nurse was observed in the nursing station and confirmed that the pharmacy aide was preparing to remove discontinued and expired medications from the home. Policy # 6.645, entitled Pharmacy-Drug Destruction, revised July 2012, states:
"All medications will be destroyed in the presence of a minimum of two individuals, the Manager/Assistant Manager of Resident Care Services or delegate and the Pharmacist".
The Assistant Manager of Operations/Resident Care and the Pharmacist acknowledged that the Pharmacy Aide should not have had access to the medication room which is a restricted area and that drugs must be destroyed by a team acting together. They also acknowledged that drugs are removed from the home in their original state. They recognized that the current practices did not comply with their policy nor meet the requirements of the LTCHA. They both confirmed that the practices surrounding drug destruction would be changed effective immediately to ensure compliance with their policies and procedures. [s. 8. (1)]

3. Policy #6.382 entitled Skin and Wound Care states "Registered staff: the resident is reassessed weekly". This policy was not complied with as evidenced by all wounds were not assessed/reassessed, weekly, during a one month time period.
The Assistant Manager of Operations/Resident Care confirmed the expectation of weekly wound assessments. [s. 8. (1)]

4. A review of the home's continence care policy #6.241, dated January 2007, revealed that it does not meet the expectations in the LTCHA and regulations.
The Assistant Manager of Operations/Resident Care confirmed the home is working on their policies and procedures for the continence care and bowel management program to ensure they are in compliance with the LTCHA. [s. 8. (1)]

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 policies and procedures related to infection control, drug destruction and skin and wound assessments are implemented in accordance with applicable requirements under the Act and are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Treatment was provided, as ordered, for an identified resident. However, there was no evidence to support weekly wound reassessments, during a one month time period.
The Assistant Manager of Operations/Resident Care confirmed the expectation was that registered staff conduct weekly wound assessments. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. A clinical record review revealed there wasn't consistent monitoring and documentation of an identified resident's response to, nor evaluation of the effectiveness of medication. A review of the Medication Treatment Record and progress notes showed that effectiveness was not noted 6 times out of the 11 times it was administered (55%) during a 7 day period.
The Nurse Practitioner confirmed that the expectation was that staff would evaluate the resident's pain and document pain levels before and after administration of pain medications and the effectiveness post administration. However, she indicated that she recognized that this was not always happening. [s. 134. (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 when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. There was no documented evidence to support that the home's quality improvement and utilization review system has a written description of its objectives, policies, and procedures. Documentation supported that the home has initiated quality improvement activities through projects. Goals have been set for 2013 related to falls, restraints and continence and bowel management.
The Assistant Manager of Operations/Resident Care acknowledged that the home resurrected the Quality Improvement committee in November 2012, although it has been conducting improvement activities informally on an ongoing basis. [s. 228. 1.]

2. There is no documentation to support that the home maintains a record setting out the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents.
The Assistant Manager of Operations/Resident Care confirmed that a written record has not always been maintained. [s. 228. 4. i.]

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 quality improvement and utilization review system has a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review and that a record of improvements made is maintained, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The door frames to nine rooms were observed to have scrapes &/or have paint chipped off.
The Environmental Services Supervisor acknowledged that the door frames were damaged and should have been painted.
The Assistant Manager of Operations/Resident Care informed inspector that the door frames will be painted April 22, 2013. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. There was no documented evidence to support that the licensee responded, in writing, to Family Council, within 10 days, despite environmental concerns being identified in the April 18, 2012 minutes.
The Assistant Manager of Operations/Resident Care acknowledged that a written response wasn't provided and that the home would implement this practice effective immediately. [s. 60. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Clinical records were reviewed for 6 residents and it was noted that 4 residents (66.6%) did not have their heights taken annually:
The Registered Dietitian indicated that heights were supposed to be taken annually, at the time of the annual care conference. She stated, after conducting her own review, that the majority of residents' heights are not being taken annually. [s. 68. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. A review of the admission package revealed that the licensee's name and telephone number was not identified correctly, as it was the name and telephone number for the home.
The Assistant Manager of Operations/Resident Care acknowledged that it was incorrect. [s. 78. (2) (h)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. A review of the "Required Postings" binder revealed that the licensee's name and telephone number was not identified correctly as it was the name and number for the home.
The Assistant Manager of Operations/Resident Care acknowledged that it was incorrect. [s. 79. (3) (h)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. There was no documented evidence to support that the Family Council's advice was sought in developing and carrying out the satisfaction survey.
The Assistant Manager of Operations/Resident Care confirmed that although the results were shared with both the Residents' Council and Family Council and input was sought at that time, they were not provided an opportunity to provide advice in developing the resident satisfaction survey before it was sent out. (112) [s. 85. (3)]

2. Actions taken to improve the long-term care home, and the care, services, programs and goods, based on the results of the satisfaction survey, were not documented and made available to the Residents' Council, and Family Council.
The Assistant Manager of Operations/Resident Care confirmed that any actions taken related to improvements made by the home were not consistently shared with both Councils. [s. 85. (4) (b)]

3. The Assistant Manager of Operations/Resident Care acknowledged that the results of the satisfaction survey have not been documented and made available to residents and their families, either. [s. 85. (4) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. An open and unattended soiled utility room, containing hazardous chemicals, was observed on April 3, 2013.
The Assistant Manager of Operations/Resident Care confirmed that the expectation was that hazardous chemicals were kept inaccessible to residents at all times. [s. 91.]

Issued on this 22nd day of April, 2013

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128), CAROLE ALEXANDER (112)
Inspection No. / No de l'inspection :	2013_182128_0008
Log No. / Registre no:	L-000163-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 22, 2013
Licensee / Titulaire de permis :	COUNTY OF OXFORD 325 Thames Street South, INGERSOLL, ON, N5C-2T8
LTC Home / Foyer de SLD :	WOODINGFORD LODGE - TILLSONBURG 52 VENISON STREET WEST, TILLSONBURG, ON, N4G-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JEN HEALEY

To COUNTY OF OXFORD, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. General requirements

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 30 (1) and (2).

1. The plan must ensure that the following interdisciplinary programs are developed and implemented in the home:
a) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
b) A continence care and bowel management program to promote continence and to ensure that
residents are clean, dry and comfortable.
c) A pain management program to identify pain in residents and manage pain.

2. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

3. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

4. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

5. The licensee shall keep a written record relating to each evaluation that

includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

6. The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented.

The plan must, also, include how staff will be provided education for each of these programs, including time frames for completion of the education.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by May 25, 2013.

Grounds / Motifs :

1. A review of the quality improvement program and policies and procedures revealed that the home was unable to demonstrate that the following interdisciplinary programs are fully developed and implemented in the home:
1. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
2. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
3. A pain management program to identify pain in residents and manage pain.

There was no documented evidence to support that there are written descriptions for each of the three required programs that include:
* goals and objectives;
* relevant policies, procedures, and protocols;
* methods to reduce risk and monitor outcomes; and
* protocols for referral of residents to specialized resources where required
The Nurse Practitioner confirmed that the home was in the midst of setting up a pain management program and indicated that when the program is implemented it will provide an opportunity for further education related to pain.
The Assistant Manager of Operations/Resident Care confirmed the home is working on continence care and bowel management, skin and wound care and

pain management programs but they have not been fully developed and implemented yet. (112)

(128)

2. Additionally, there was no evidence to support that there were screening protocols and assessment and reassessment instruments in place for each of the three required programs noted above, as evidenced by:
1. A clinical record review revealed that an identified resident has not had a pain assessment done using a clinically appropriate assessment instrument specifically designed to assess pain.
A Registered Nurse confirmed that a Pain Flow record was initiated, for this resident, after the MOHLTC in inspectors identified the need for pain assessment/evaluation during this inspection.

2. A clinical record review revealed that an identified resident has not had a pain assessment done using a clinically appropriate assessment instrument specifically designed to assess pain.
A Registered Nurse stated that the home does not have a pain assessment tool but a pain management program is in the process of being developed.
The Nurse Practitioner indicated that although the home does have pain assessment tools, she recognized that they are not always utilized.

(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

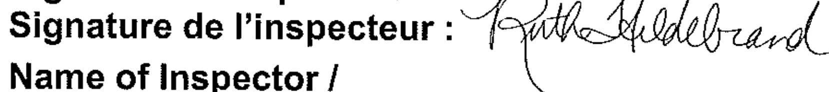
À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of April, 2013

Signature of Inspector / Signature de l'inspecteur :



Name of Inspector / Nom de l'inspecteur : RUTH HILDEBRAND

Service Area Office / Bureau régional de services : London Service Area Office