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

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 25, 2015	2015_262523_0016	010395-15	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 - INGERSOLL
325 THAMES STREET SOUTH INGERSOLL ON N5C 2T8

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

ALI NASSER (523), ALICIA MARLATT (590), RAE MARTIN (515)

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): June 9, 10, 11, 12, 15, 16, 17 & 18, 2015

The following Critical Incident inspection related to staff to resident abuse was conducted concurrently during this inspection:
Log # 007813-14 / M614-000009-14

During the course of the inspection, the inspector(s) spoke with the Manager of the home, Manager of Resident Care, RAI Co-ordinator, 10 Personal Support Workers (PSW), five Registered Staff, three Family Members, Resident Council Representative & 33 Residents.

The inspector(s) also conducted a tour of the home including resident and common areas, observed residents, resident/staff interactions, activities and care provided. Observed meal and snack services, infection prevention and control practices and medication pass & medication storage areas. Reviewed health records and plans of care for identified residents, reviewed relevant policies and procedures and observed general maintenance cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The Licensee has failed to ensure that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During the Resident Quality Inspection, inspectors observed on 3 different occasions that resident's personal health information (PHI) was accessible and not kept confidential. This was confirmed by the RAI Co-ordinator and the two Registered Staff Members. s. 3. (1) 11. 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 every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: 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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident.

A) Throughout the Resident Quality Inspection, Resident # 006 was observed using a PASD.
A clinical record review for resident # 006 revealed that the PASD use was directed in the care plan.
A review of the care guide in the resident's bathroom revealed that (None) was circled for the PASDs to be used.
An interview with the RAI Co-ordinator confirmed that the plan of care did not set out clear direction to staff as the care plan intervention directed the use of PASDs and the care guide indicated no PASDs were to be used. The RAI Co-ordinator confirmed that it is the home's expectations that the plan of care would set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

B) Throughout the Resident Quality Inspection, Resident # 003 was observed using a PASD.
A clinical record review revealed that the care plan included an intervention to use this PASD.
Observation of the posted resident care guide in the resident's bathroom revealed that this PASD was not circled to be used.
A Registered Nurse confirmed the observation and indicated that the PASD should be circled.
A Registered Nurse confirmed that the plan of care did not provide clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A clinical record review for four residents revealed that there was no documentation that reflects certain interventions in relation to use of PASD and Toileting Routine in the plan of care were completed.
The Manager and the RAI Co-ordinator both confirmed that there was no manual or electronic documentation established in the home whereby a PSW can document the provision of care set out in the plan of care. [s. 6. (9) 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 the plan of care set out clear direction to staff and others who provide direct care to the resident, and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a controlled substance was stored in a separate locked area within the locked medication room.

On June 16, 2015, observation of the medication refrigerator revealed a plastic vial containing two ampules of a controlled medication were found in the drawer of the refrigerator.
A Registered Nurse confirmed the observation.
In an interview, the Manager confirmed the home's expectation was that controlled substances are to be stored separately and double-locked. [s. 129. (1) (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 a controlled substances are stored in a separate locked area within the locked medication room, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' written records are kept up to date at all times.

A review of Medication Administration Records (MAR) for three residents revealed that medications and supplements were not documented as administered:
Resident # 003: 7 signatures were missing.
Resident # 004: 13 signatures were missing.
Resident # 011: 3 signatures were missing.
A Registered Nurse confirmed the observations.
The Manager confirmed the home's expectation that the MAR's are signed after a medication is administered and that the residents' written records are kept up to date at all times. [s. 231. (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 residents' written records are kept up to date at all times, to be implemented voluntarily.

WN #5: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to obtain approval and consent for the use of a personal assistance services device (PASD).

A) A clinical record review for resident # 006 revealed that a PASD was used by the resident.
A further review of the resident's clinical record revealed that there was no consent obtained from the resident/substitute decision-maker for the use of the PASD.
The manager confirmed that there was no consent obtained for the use of the PASD.
The Manager confirmed the home's expectation that consent would be obtained prior to the use of PASDs. [s. 33. (4) 4.]

B) A clinical record review for resident # 003 revealed that a PASD was used by the resident.
A further review of the resident's clinical record revealed there was no documented evidence that a PASD had been approved by a physician or nurse, or that consent had been obtained from the resident/substitute decision-maker for the use of the PASD.
This was confirmed by a Registered Nurse and the Manager.
The Manager confirmed the home's expectation is that approval and consent would be obtained prior to the use of PASD. [s. 33. (4)]

Issued on this 8th day of July, 2015

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

Original report signed by the inspector.