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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 16, 2014 | 2014_243504_0020 | L-000002-14 | Complaint |

**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**

DEIRDRE BOYLE (504)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): July 9 and 10, 2014.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Director of Care, the Director of Human Resources, one Registered Nurse four Personal Support Workers and eleven residents.**

**During the course of the inspection, the inspector(s) reviewed the clinical records of three residents, the home's Critical Incident history, staffing levels, supplemental staffing record and schedules, Prevention of Abuse and Neglect policies and staff education records.**

**The following Inspection Protocols were used during this inspection:**

**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident was prescribed a certain medication for a diagnosed condition. The resident did not receive the medication as ordered by the Physician. This was confirmed by the Director of Care and the Acting Director of Care. [s. 6. (7)]

2. A resident's care plan sets out direction to staff to implement specified interventions when indicated. The resident received the interventions when indicated for the month of April, 2014 but not when indicated in May, June or up to July 10, 2014. This was confirmed by the Director. The resident should have had the care set out in the care plan but did not receive the care set out in the plan. This was confirmed by the Registered Nurse and by the Director. [s. 6. (7)]

***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 care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

There have been reports of a resident having altercations with staff and residents. This was confirmed by review of the resident's clinical records and through interview with four Personal Support Workers and the Registered Nurse. The procedures and interventions in place were not successful in assisting the staff who are at risk of harm or who are harmed as a result of the resident's responsive behaviours. [s. 55. (a)]

2. A resident reported to staff that they had been in an altercation with another resident. This was confirmed through review of both residents' clinical records, interview with the resident, interview with two Personal Support Workers and by the Acting Director of Care.

Review of the clinical record for a resident revealed that there were no documented procedures and interventions in place to minimize the risk of altercations and potentially harmful interactions between the two residents. This was confirmed by the Registered Nurse. [s. 55. (a)]

3. The licensee has failed to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

This was confirmed by four Personal Support Workers, the Registered Nurse and the Director. [s. 55. (b)]

**Issued on this 17th day of July, 2014**

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