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
Jun 26, 2018	2018_607523_0011	009919-16, 015977-16, 025246-16, 033976-16, 000016-17, 002705-17, 006626-17, 007956-17, 011278-17, 012818-17, 015607-17, 017015-17, 021530-17, 025090-17, 001061-18, 002299-18, 002756-18, 007166-18	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

ALI NASSER (523), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569), RHONDA KUKOLY (213)

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): May 28, 29, 30, 31, June 1, 4 and 5 2018.

The following intakes were completed during this inspection:
Critical Incident intake Log #009919-16, CIS #M632-000015-16 related to a resident's fall.
Critical Incident intake Log #025246-16, CIS #M632-000027-16, related to alleged resident to resident physical abuse.
Critical Incident intake Log #033976-16, CIS #M632-000034-16, related to a resident's fall.
Critical Incident intake Log #000016-17, CIS #M632-000036-16, related to alleged resident to resident physical abuse.
Critical Incident intake Log #002705-17, CIS #M632-000001-17, related to alleged resident to resident physical abuse.
Critical Incident intake Log #006626-17, CIS #M632-000003-17, related to a resident's fall.
Critical Incident intake Log #007956-17, CIS #M632-000004-17, related to alleged resident to resident physical abuse.
Critical Incident intake Log #011278-17, CIS #M632-000009-17, related to a resident's fall.
Critical Incident intake Log #012818-17, CIS #M632-000011-17, related to alleged resident to resident physical abuse.
Critical Incident intake Log #015607-17, CIS #M632-000012-17, related to alleged resident to resident physical abuse.
Critical Incident intake Log #017015-17, CIS #M632-000017-17, related to a resident's fall.
Critical Incident intake Log #021530-17, CIS #M632-000024-17, related to alleged resident to resident sexual abuse.
Complaint intake Log #025090-17, IL-53823-LO related to resident's specific care concerns.
Critical Incident intake Log #001061-18, CIS #M632-000003-18, related to alleged resident to resident sexual abuse.
Critical Incident intake Log #002299-18, CIS #M632-000004-18, related to missing controlled substance.
Critical Incident intake Log #002756-18, CIS #M632-000006-18, alleged resident to resident physical abuse.
Critical Incident intake Log #007166-18, CIS #M632-000013-18, related to disease outbreak.

Complaint intake Log #015977-16, IL-44780-LO related to alleged resident to resident physical abuse.
Critical Incident inquiry Log #016579-17, CIS #M632-000015-17, related to a resident's fall.
Critical Incident inquiry Log #000329-18, CIS #M632-000001-18, related to alleged staff to resident physical abuse.
Complaint inquiry Log #004306-18, IL-NC-55754 related to a resident's fall.

During the course of the inspection, the inspector(s) spoke with The administrator, Acting Director of Care, two Resident Care Coordinators, RAI Coordinator, Two Behavioural Support Ontario staff members, 10 registered staff, seven Personal Support Workers, three family members and 15 residents.
The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, observed controlled substance count, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted CIS report to the Ministry of Health and Long-Term Care which was identified as an incident of resident to resident sexual abuse.

The Critical Incident Systems (CIS) report showed the CI was submitted a day after the incident had occurred.

During the inspection, a Resident Care Coordinator (RCC) said in an interview that the incident was not reported to the on-call manager that evening, but should have been.

A review of the home's policy entitled "Resident Abuse – Zero Tolerance for Abuse and Neglect" with a revision date of November 2017, stated the following:
"Employee(s) who are reporting that they have witnessed, or suspect alleged incident of resident abuse or neglect:
-report any witnessed, suspected, or alleged abuse to the RN, supervisor/manager, Administrator immediately."

The licensee has failed to ensure that the Home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported to the licensee, was immediately investigated.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care, which was identified an incident of resident to resident sexual abuse.

Section 2(1)(b) of Ontario Regulation 79/10 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of the home's policy entitled "Resident Abuse – Zero Tolerance for Abuse and Neglect" with a revision date November 2017 stated under "Appendix A: Definition of Abuse and Neglect" the following definition:
"Sexual abuse means:
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A review of the home's policy entitled "Resident Abuse – Zero Tolerance for Abuse and Neglect" showed the following:
"Woodingford Lodge will immediately investigate all reports by staff under this policy, and

third party report of abuse or neglect, in accordance with the MOHLTC investigation procedures for reporting and notifications."

The clinical record review for a specific resident showed that on multiple occasions the staff had found the resident involved in interactions of a sexual nature with co residents, co resident seemed not to resist.

On a specific date a Registered Practical Nurse (RPN) said in an interview that the process for determining consent was not in the Home's abuse policy. After review of the definition of sexual abuse from the Home's policy entitled "Resident Abuse – Zero Tolerance for Abuse and Neglect", the RPN said that based on the definition, these incidents were considered to be sexual abuse.

In an interview the Acting Director of Care said that this incident was sexual abuse and the fact that the resident was not resisting and did not appear upset did not mean that they consented.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported to the licensee, was immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm, had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation 79/10 s. (2) states, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident;

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific sate related to resident to resident physical abuse.

A review of the CIS showed that on a certain date the two specific residents had an altercation in a resident's common area that resulted in an injury to one of the residents.

The CIS stated that the RPN informed the RN about the incident. The RPN completed a risk management and RN emailed the RCC and notified the manager on call right after the incident occurred.

In an interview the RCC and ADOC said that it was the home's expectation and the home's policy that the RCC during business hours and the on call manager afterhours

would report the allegations of abuse to the Director.

The RCC and ADOC reviewed the CIS and said that this incident of resident to resident physical abuse that resulted in an injury to the resident should have been reported to the director immediately. [s. 24. (1)]

2. The licensee failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm, had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation 79/10 s. (2) states, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident;

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date related to resident to resident physical abuse.

A review of the CIS showed that on a certain date two specific residents had an unwitnessed altercation that resulted in an injury to one of the residents.

The CIS stated that the MOHLTC after hours pager was not contacted about this incident.

In an interview a specific RCC said that they were on call at the time of the incident, the RCC said that they considered the incident to be a resident to resident physical abuse that resulted in an injury to a resident. RCC said that it was the expectation that they would have informed the Director about the incident. The RCC said that they did not inform the Director about the incident at that night, they initiated the CIS in the next morning.

In an interview the RCC and ADOC said that it was the home's expectation and the home's policy that the RCC during business hours and the on call manager afterhours would report the allegations of abuse to the Director.

The RCC and ADOC reviewed the CIS and said that this incident was of resident to resident physical abuse that resulted in an injury to the resident should have been reported to the director immediately. [s. 24. (1)]

3. The licensee failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm, had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A review of a specific Critical Incident identified that on a certain date a specific resident demonstrated physical responsive behaviours towards another resident, causing the resident to fall and sustain an injury. The Critical Incident (CI) was submitted to the Ministry of Health two days after the specific incident had occured. The CI stated that the Ministry after hours pager was not contacted about the incident.

The home's policy Resident Abuse – Zero Tolerance for Abuse and Neglect, Number 6.045, with a revision date of November 2017, stated that everyone (other than another resident) has the duty to immediately report specified issues including abuse of a resident by anyone to the Director at the Ministry of Health and Long Term Care MOHLTC), if it is known or there are reasonable grounds to suspect that the resident has been harmed or might be harmed.

In an interview with RCC / Acting Director of Care acknowledged that incident was resident to resident physical abuse that was not immediately reported to the Ministry immediately as per the legislative requirements. [s. 24. (1) 2.]

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 person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm, had occurred or may occur, would immediately report the suspicion and the information upon which it was based to the Director., to be implemented voluntarily.

WN #4: 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. (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 provision of the care set out in the plan of care were documented.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date related to a resident's fall.

A clinical record review for the specific resident showed that on a certain date the resident had a fall that resulted in an injury which required transfer to hospital.

A clinical record review, plan of care showed that the resident was a high risk for falls. Staff were to complete a specific intervention.

A review of the task report for the specified period of time when the resident had the fall with the ADOC showed that there was no tasks assigned for the specific intervention. A review of the progress notes for the date the resident had the fall showed no documentation that the specific intervention was completed.

ADOC said that they do not document the specific intervention in the clinical record. ADOC said that the provision of care set out in the plan of care was not documented. [s. 6. (9) 1.]

Issued on this 5th day of July, 2018

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

Original report signed by the inspector.