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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_607523_0035	016769-18, 017422-18	Complaint

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)

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): November 30, December 3, 4, 5, 6 and 10, 2018.

This inspection was conducted concurrently with inspection #2018_607523_0034.

The following intakes were completed during this inspection:
Critical Incident intake Log #016769-18, related to alleged staff to resident neglect.
Complaint intake Log #017422-18 related to skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Behavioural Support Ontario Supervisor, Skin and Wound Nurse, four Registered Staff members, seven Personal Support Workers, one family member and four residents.

The inspectors also observed resident rooms and common areas, observed resident and the care provided to them, observed staff-resident and resident-resident interactions, reviewed health care records and plans of care for identified residents, reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report on a certain date related to alleged staff to resident neglect.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) info-line related to a resident's specific care concerns.

A clinical record review for the resident showed that the resident had a specific condition that required a daily intervention and treatment to be completed by the Registered staff members. On a specific date the staff and family found a care concern specific to this condition.

A review of the resident's Treatment Administration Record (TAR) for a certain period of time showed that on a specific date there was no initials that the treatment was completed.

In an interview Acting Director of Care (ADOC) said that once the care concerns were identified they initiated an immediate investigation with the staff and found out that the specific treatment was not provided to the resident on that specific date, and that the staff did not complete this task that was part of the care in the plan of care.

In an interview a specific RPN said that they were aware of the resident's specific task but on that date they were extremely busy and they did not get to complete this task and couldn't remember if they informed the upcoming staff to complete this task.

In an interview the Administrator said that the home initiated immediate investigations into the alleged staff to resident neglect. Administrator said they found out that the specific treatment was not completed to the resident on that specific date.

The Administrator said that the expectation was that care set out in the plan of care would be provided to the resident as specified in the plan. [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.

Issued on this 17th day of December, 2018

[redacted]

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

Original report signed by the inspector.