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
Mar 14, 2019	2019_777731_0008	001988-19, 002266-19, 002519-19	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

KRISTEN MURRAY (731), NATALIE MORONEY (610)

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): March 11 and 12, 2019

The following Critical Incident intakes were completed within this inspection

Related to falls prevention:
Critical Incident Log #002266-19/ CIS #M632-000003-19
Critical Incident Log #002519-19/ CIS #M632-000004-19

Related to the prevention of abuse and neglect:
Critical Incident Log #001988-19/ CIS #M632-000001-19

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC), the Clinical Care Co-ordinator (CCC), the BSO Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspectors also observed residents and the care provided to them, observed resident rooms and common areas, reviewed health care records and plans of care for identified residents, reviewed the home's internal investigation documentation and reviewed policies of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

a) This inspection was completed related to a Critical Incident System (CIS) report submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date related to a complaint received regarding an identified resident. The complainant had care concerns related to specific symptoms on a specific area of the resident's body and other personal care while at the home.

Record documentation showed that the identified resident was admitted to the home on a specified date, to a specific area of the home, and had been discharged on a specified date.

Further record documentation review showed that on a specified date, the identified resident had refused to be bathed. There was no further documented evidence that the resident had received a bath of choice during the specific time-frame.

The CIS report submitted by the home to the MOHLTC showed that the internal investigation notes indicated that "after speaking with all the staff it was discovered that this resident did not receive any form of bathing during" the specific time-frame.

On a specified date, the complainant told the Inspector that the home did follow up with the care concerns, however they were not aware that the identified resident had not received bi-weekly bathing of their choice.

B) Another identified resident was admitted to the home on a specified date.

Record documentation showed that the identified resident on a specific date, refused their bath.

On a specific date, a specific number of days after being admitted to the home, the resident had a bath of choice.

On a specified date, the identified resident was discharged from the home. There was no record of documented evidence that the resident had received biweekly bathing of their choice during the specific time-frame.

The home's policy "Refused/Missed Baths" revised on a specific date stated in part that: If a resident refuses to be bathed it is the responsibility of the PSW to inform the registered staff and the resident will receive a bath on the following shift if time permits.

The home's policy "Baths" revised on a specific date stated in part that:
All residents will be bathed at a minimum of twice a week by the method of their choice.

On a specified date, the BSO Manager said that they did not complete the bi-weekly baths for the identified resident, and should have, and that the other identified resident also did not receive a bi-weekly bath during the specific time-frame.

The Clinical Care Coordinator (CCC) said the expectation was that all residents would be bathed at least bi-weekly and that when a resident refused to be bathed the staff would reapproach the residents and/or offer the bath on another day.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

On a specified date, the home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall of an identified resident during a specific task of the resident on a specified date, which resulted in an identified injury to the resident.

In the CIS report submitted to the MOHLTC, the home stated that a specific intervention was used for the identified resident to help prevent a specific injury, which caused the resident to fall. The CIS report stated that the specific intervention was removed as an intervention for the resident and would no longer be used.

A review of the identified resident's care plan on a specified date, stated in part, that staff were to apply and use an identified intervention, in two separate areas of the care plan under current interventions in place for the resident.

In an observation of the identified resident on a specific date the resident did not have the identified intervention in place.

During an interview with a staff member, the staff member stated that they would look for current resident interventions in the binders located in the home's documentation room. In an interview with another staff member, the staff member stated they would look for information regarding current resident interventions electronically in the Kardex, or in paper form in the documentation room. When asked how the staff were made aware of changes to a resident's plan of care, the staff member stated they would find changes in

the FYI book, located in the documentation room, and in report.

In an interview with a registered staff member, they indicated that the identified intervention had been used for the specific resident. When asked if this intervention was currently in place for the resident, the registered staff member stated it was not. When the registered staff member pulled up the care plan for the resident, they identified that the intervention was currently in the care plan, but that it was to be removed as the intervention had not been used since the resident sustained their fall. When asked how staff would know about the change to the identified resident's plan of care related to the discontinued intervention, the registered staff stated the information would be in the communication binder. When asked to show the Inspector where this information would be in the binder, the registered staff member was unable to locate the information regarding the discontinued intervention for the resident in the communication binder. When asked if there was anywhere else the change in plan of care would have been communicated to staff, the registered staff member stated in the notes. The registered staff member reviewed the notes for the resident and stated they could not find anything related to the discontinued intervention. The registered staff member stated the intervention was no longer used for the resident and communication to staff may have been done verbally.

In an interview with the Clinical Care Coordinator (CCC), when asked how staff would know about changes to a resident's plan of care after a fall, the CCC stated that a discussion would take place with staff about the fall, charting would be completed, staff would have access to the updated care plan, and the staff would read report when they signed into the system.

A review of the home's policy "Documentation – Care Plan", number 6.160, stated in part "The care plan is reviewed and updated by the disciplines when new information that impacts the Resident care is made known, a change in Resident status and on a quarterly basis.".

The licensee failed to ensure that there was a written plan of care for the identified resident that set out clear directions to staff and others who provided direct care to the resident related to the use of the specific intervention for the identified resident. [s. 6. (1) (c)]

Issued on this 15th day of March, 2019

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

Original report signed by the inspector.