Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 22, 2021	2021_725522_0012	009133-21, 009416-21, 010142-21, 010496-21, 011054-21, 012035-21, 013955-21	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

JULIE LAMPMAN (522)

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): September 27, 28, 29, October 1, 4, 5, 6, 7, 12, 13, 14, and 15, 2021.

The following intakes were inspected during this inspection:

Critical Incident System (CIS) report #M632-000034-21/Log #013955-21 related to a medication incident;
CIS report #M632-000033-21/Log #012035-21 related to resident to resident abuse;
CIS report #M632-000031-21/Log #011054-21 related to resident to resident abuse;
CIS report #M632-000030-21/Log #010496-21 related to resident to resident abuse;
CIS report #M632-000026-21/Log #009416-21related to resident to resident abuse;
CIS report #M632-000025-21/Log #009133-21 related to resident to resident abuse;
CIS report #M632-000028-21/Log #010142-21 related to resident to resident abuse.

Complaint Inspection #2021_725522_0011 was inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Services, Resident Care Coordinators, IPAC Lead/Nurse Practitioner, Supervisor of Resident Programs and Staff Education, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Recreation Staff, a Housekeeper, Screeners, a PSW Student, residents.

The inspector also observed infection prevention and control practices in the home, resident to resident interactions, staff to resident interactions, the provision of resident care, and a medication administration pass, reviewed resident clinical records, medication incident reports, meeting minutes, staff training records, and policies and procedures related to this inspection.

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

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
3 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents #010 and #011 in accordance with the directions for use specified by the prescriber.

A) A Critical Incident Systems (CIS) report was submitted to the Ministry of Long-Term Care related to a medication incident where Registered Practical Nurse (RPN) #116 administered the wrong dose of medication to resident #010.

Review of resident #010's electronic progress notes in Point Click Care (PCC) noted when resident #010 was administered the wrong dose of medication, resident #010 had an adverse reaction.

In an interview, RPN #116 stated they were distracted by other residents when administering the medication to resident #010 and after they administered the medication and went to sign off in the electronic Medication Administration Record (eMAR) they noticed the error.

In an interview, the Manager of Resident Services (MRS) stated they followed up with RPN #116 after the RPN administered the wrong dose of medication to resident #010. The MRS reviewed their tracking documents and acknowledged RPN #116 had also administered the wrong dosage of medication to resident #011.

B) Review of CareRx Medication Incident/Near Miss Reports noted on two consecutive shifts RPN #116 administered the wrong dose of medication to resident #011.

Review of resident #011's progress notes noted there was no harm from either medication error.

In an interview, RPN #116 stated they were distracted on both dates and misread resident #011's orders in the eMAR.

In an interview, Resident Care Coordinator (RCC) #109 stated they spoke with RPN #116 after the medication errors with resident #011.

Sources:
Review of resident #010 and #011's clinical records, including eMAR and physician orders; CIS report #M632-000034-21; CareRx Medication Incident/Near Miss Reports; and interviews with RPN #116, RCC #109 and the MRS. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) Observations of a meal service in a specific home area dining room noted a Personal Support Worker (PSW) student brought two residents into the dining room and assisted them to apply their clothing protectors. The residents were not assisted with hand hygiene prior to their meal.

In an interview, PSW #119 acknowledged that hand hygiene was not completed with residents prior to the meal. PSW #119 stated staff get busy and at times hand hygiene gets overlooked.

In an interview, the Manager of Resident Services (MRS) stated staff should go around in the dining room with hand sanitizer before meals to assist residents to sanitize their hands.

B) On a specific date, Inspector #522 observed two staff members enter the home and be screened by Screener #111. Staff removed and disposed of their dirty surgical mask, took a clean surgical mask from a container on the screener's table, put on the clean surgical mask and walked away. At no point did either staff member sanitize their hands.

In an interview, Screener #111 stated they did not notice that the staff members did not sanitize their hands and did not realize they should monitor hand hygiene.

In an interview, MRS stated Screeners were expected to monitor staff and visitors entering the home to ensure that they were sanitizing their hands properly when they were removing their dirty mask and putting on a clean mask.

C) On a specific date, during observation of a medication pass, Inspector #522 observed Registered Practical Nurse (RPN) #116 administer medications to two residents without using hand hygiene.

In an interview, RPN #116 acknowledged they did not sanitize their hands when they administered the medications. RPN #116 stated they sanitized their hands when they gave an injectable medication or if they had to touch medication.

In an interview, Resident Care Coordinator (RCC) #115 stated registered staff should sanitize their hands before and after administering medications.

Review of the home's "Hand Hygiene" policy noted in part, that hand hygiene should be performed before preparing, handling, or serving food or medications to a resident; when in doubt; and staff should encourage residents to perform hand hygiene prior to eating.

Not following the home's "Hand Hygiene" policy put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources:
Review of the home’s “Hand Hygiene” policy #2.02 with a review/revision date of April 6, 2020; observations of the home’s Infection Prevention and Control practices, including dining, screening and medication administration; and interviews with Screener #111, Screener #112 RPN #116, RCC #115, and the MRS. [s. 229. (4)]

2. The licensee failed to ensure that staff monitored symptoms of infection in residents

#001, #002, #013 and #014 on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A) Resident #001 was placed in isolation on a specific date.

A review of resident #001's electronic progress notes in Point Click Care (PCC) noted the absence of documentation related to monitoring resident #001 for signs and symptoms of infection while they were isolated.

In an interview, the Manager of Resident Services (MRS) stated if a resident was in isolation registered staff would make a progress note each shift about how the resident was doing.

The MRS stated it was a nursing best practice that staff should be monitoring resident #001 for symptoms each shift.

B) Resident #002 was placed in isolation on a specific date.

A review of resident #002's electronic progress notes in PCC noted registered staff did not take resident #002's vitals when they became ill and were placed in isolation.

C) Resident #013 was placed in isolation on a specific date.

A review of resident #013's electronic progress notes in PCC noted missing documentation for 10 shifts during the isolation period.

Further review of resident #013's clinical record noted when resident #013 became unwell registered staff did not complete a set of vitals on resident #013, including a temperature check.

D) Resident #014 was placed in isolation on a specific date.

A review of resident #014's electronic progress notes in PCC noted missing documentation for seven shifts during the isolation period.

Further review of resident #014's clinical record noted when resident #014 became unwell registered staff did not complete a set of vitals on resident #014, including a temperature check.

Residents were put at risk by not having a baseline set of vitals and being monitored each shift for signs and symptoms of infection as there was no documentation to determine if the resident's condition was worsening.

Sources:
Review of resident #001, #002, #013 and #014's electronic clinical records and interviews with Infection Prevention and Control Lead/ Nurse Practitioner and RCC #109 and the Manager of Resident Services. [s. 229. (5) (a)]

3. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

Review of resident #014's electronic progress notes in Point Click Care (PCC) noted an entry on a specific date, that earlier in the day resident #014 displayed signs and symptoms of an infection. Staff noted they would continue to monitor the resident.

Progress notes dated the following day, indicated that resident #014 was put in isolation.

In an interview, Resident Care Coordinator (RCC) #109 reviewed resident #014's progress notes with Inspector #522. RCC #109 stated resident #014 should have been put in isolation the day they displayed symptoms, as there were other residents in the same home area with symptoms.

Other residents were put at risk of developing a infection by not placing resident #014 in isolation as soon as they developed symptoms of an infection.

Sources:
Review of resident #014's clinical record, including progress notes; the home's Respiratory-Outbreak Protocol (Contingency Plan)-Residents and Staff policy #4.00 with a review date of April 6, 2020; interview with RCC #109. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and that staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medication incidents involving resident #011 were documented, together with a record of the immediate actions taken to assess resident #011 and was reported to the Medical Director and the prescriber of the drug.

A) Review of CareRx Medication Incident/Near Miss Reports noted on two consecutive shifts RPN #116 administered the wrong dose of medication to resident #011.

Further review of CareRx's Medication Incident/Near Miss Reports for resident #011 noted the for the first medication incident the report did not include the specific incident

type, contributing factors and follow up actions.
For the second medication incident the report did not include the type of incident and specific incident type, contributing factors, follow up actions and effect on the resident.

Review of resident #011's electronic clinical record in Point Click Care (PCC) noted no progress notes related to the medication incident, an assessment of the resident, vitals taken or follow up actions taken. There was no assessment of resident #011 documented until four days after the first medication incident, which was completed by Resident Care Coordinator (RCC) #109.

In an interview, Registered Nurse (RN) #118 stated they discovered the first medication incident. RN #118 stated they could not recall if they assessed resident #011 or took their vitals. RN #118 stated they would have documented the assessment in a progress note if they had completed one. RN #118 stated they did not inform RPN #116 of the medication incident.

In an interview, RPN #116 stated they were never informed of the first medication incident. RPN #116 acknowledged they made the same medication error the following shift and that they were informed of both errors several days later.

Registered staff did not document the medication incident involving resident #011 in the resident's progress notes and take action by informing RPN #116 of the medication incident, as per Woodingford and CareRx's policies, this put resident #011 at actual risk of harm as RPN #116 made the same medication error the following shift.

B) Further review of CareRx Medication Incident/Near Miss Reports for resident #011 noted no indication that the prescriber and Medical Director had been notified of the medication incidents.

Further review of the CareRx Medication Incident/Near Miss Report noted there was no area on the report to indicate that the Medical Director had been notified. There was a section on the Medication Incident/Near Miss Report which indicated "Medical Director Review Signature (for harm incidents)"

In an interview, the Manager of Resident Services (MRS) stated the Medical Director was not notified of each medication incident when they occurred rather, they signed off that they reviewed the quarterly CareRx Medication Incident/Near Miss Summary Reports.

Sources:
Review of resident #011's clinical records; CareRx Medication Incident/Near Miss Reports, CareRx Medication Incidents policy #4.12 with a revision date of February 28, 2020; the home's Documentation & Reporting Incidents and Adverse Reactions policy #6.640 revised/reviewed September 1, 2020; Safe Medication Administration Team Review Team minutes dated May 14, 2021; and interviews with RN #118, RPN #116, RCC #109 and the MRS. [s. 135. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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 failed to ensure that resident #001 and #002's plan of care provided clear direction regarding isolation precautions.

A) On a specific date, Inspector #522 observed generic isolation signage posted outside resident #001's room. The signage did not specify the type of isolation resident #001 was in.

In an interview, Personal Support Worker (PSW) #103 showed inspector #522 isolation precaution signage inside resident's room on the bathroom door.

In an interview, Registered Practical Nurse (RPN) #120 stated resident #001 should have had different isolation precaution signage posted and was not sure why the other signage was posted.

B) On a specific date, Inspector #522 observed generic isolation signage posted outside resident #002's room. The signage did not specify the type of isolation resident #002 was in.

In an interview, RPN #105 stated they had put resident #002 in isolation and posted the generic isolation sign as they were going into a meeting. RPN #105 stated they had just come from the meeting and they were going to post the appropriate isolation precaution signage.

In an interview, the Manager of Resident Services (MRS) stated instead of posting a generic isolation sign, staff should have posted the appropriate precaution signage outside resident #002's room when resident #002 was placed in isolation.

Posting incorrect signage placed residents at risk as there was the potential that staff may not wear the appropriate personal protective equipment when providing care to resident #001 and #002.

Sources:
Review of resident #001 and #002's clinical records; Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 2.1 dated July 23, 2021; the home's COVID 19 Pandemic Preparedness and Response in the Woodingford Lodge Long Term Care Home with a revised date of December 2020; interviews with PSW #103, RPN #105, RPN #107, RPN #120, IPAC Lead/Nurse Practitioner, and the Manager of Resident Services. [s. 6. (1) (c)]

2. The licensee has failed to ensure dementia observation system (DOS) and behaviour monitoring was documented for resident #005 and #007.

A) i) Resident #005 was involved in altercations with residents #004 #006, and #007 and DOS charting was initiated for a specific time frame for each incident.

Review of the DOS charting for the time frames noted the documentation was not completed in full for resident #005.

ii) Review of resident #005's plan of care noted resident #005 had behaviours of verbal and physical aggression and staff were to complete safety checks and monitor resident #005 for behaviours and mood.

Review of resident #005's Point of Care (POC) documentation for a specific month, in the home's Documentation Survey report noted staff were to monitor the resident for behaviours and mood every shift and to complete safety checks. Documentation was noted to be missing on several occasions.

B) i) Resident #007 was involved in a altercation with resident #005 and DOS charting was initiated from for a specific time frame.

Review of the DOS charting for the above time frame noted the documentation was not completed in full for resident #007.

ii) Review of resident #007's plan of care noted resident #007 had behaviours of verbal and physical aggression and staff were to monitor resident #007 for behaviours, mood and pain.

Review of resident #007's Point of Care (POC) documentation for a specific month, in the home's Documentation Survey report noted staff were to monitor the resident for behaviours, mood and pain every shift. Documentation was noted to be missing on several occasions.

In an interview, Resident Care Coordinator (RCC) #115 stated Personal Support Workers should document behaviours, moods, DOS and that safety check were completed.

In an interview, the Behaviour Supports Ontario Coordinator (BSO-C) stated it was important for staff to complete DOS documentation as they used the information to assess the resident.

Missing documentation regarding resident #005 and #007's behaviours put the residents at risk as the documentation is not consistent to accurately reflect how the resident is doing with interventions in place.

Sources:
Review of resident #005 and #007's clinical records, including DOS charting and POC; the home's Documentation-General policy #6.165 with a review/revised date of March 2020; and interviews with RPN #114, RCC #115 and the BSO-C [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 a resident's plan of care provides clear direction regarding isolation precautions and care provided as per the plan of care is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs.

Record Review of the following resident’s electronic Medication Administration Records (eMARs) and physician’s orders noted the medications ordered had no indication for use.

Resident #010 was ordered regular doses of two controlled drugs, along with other medications with no indication for use. Resident #010 was also ordered as needed (prn) medications with no indication for use.

Resident #011 was ordered a medication with no indication for use.

Resident #005 was ordered regular doses and prn doses of medications with no indication for use.

Resident #004 was ordered regular doses of a controlled drug, along with other medications with no indication for use. Resident #004 was also ordered prn doses of a controlled drug, along with other medications with no indication for use.

Resident #006 was ordered regular doses of a controlled drug, along with other medications with no indication for use. Resident #006 was also ordered prn doses of a controlled drug, along with other medications with no indication for use.

In an interview, Resident Care Coordinator (RCC) #115 stated the Nurse Practitioner was working on including indications for use on medications when they were doing their quarterly medication reviews.

Not including the indication for use for medications, especially prn controlled drugs, puts the resident at risk as the order does not indicate the specific need of when the medication should be given, leaving registered staff to use their own judgement which could potentially contribute to a medication error.

Sources:
Review of Resident #004, #005, #006, #010 and #011’s eMARS and physician orders; Professional Advisory Committee (PAC) meeting report dated July 21, 2021; and interview with RCC #115. [s. 117. (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 all orders for the administration of a drug to a resident is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On a specific date, Inspector #522 went to a resident home area to observe a medication pass with Registered Practical Nurse (RPN) #116. When Inspector #522 entered the hallway, they observed a medication cart unlocked and unattended outside a resident's room. Inspector #522 waited several minutes and noted the registered staff was in a room with a resident and had their back to the door.

The medication cart was not visible from the resident's room and a resident was observed standing in front of the medication cart.

After five minutes, RPN #116 came out of the resident's room and proceeded down the hall to another resident's room. RPN #116 pulled open the bottom drawer of the medication cart and opened the narcotic box without using a key. RPN #116 went into the resident's room and left the medication cart open and unattended.

RPN #116 then went down the hallway to the lounge, part way down the hallway inspector observed RPN #116 push in the lock on the medication cart. When RPN #116 reached the lounge, Inspector #522 observed RPN #116 pull open the medication cart lock without using a key.

In an interview, RPN #116 stated they only pushed the medication cart lock in slightly so it would not lock and did not have to use the key to open the medication cart. RPN #116 stated they sometimes forgot to lock the medication cart when they were administering medications as they would get busy and forget.

To leave the medication cart unlocked and unattended with the narcotic box unlocked put residents at risk, as residents could access medications, including narcotics, within the unlocked medication cart.

Sources:
Observation of a medication pass; CareRX's Medication Storage Areas policy #3.2 with a revision date of August 15, 2018; CareRX's Narcotic and Controlled Medication Lock Box policy #3.8 with a revision date of August 15, 2018; and interviews with RPN #116, RCC #115 and the Manager of Resident Services. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: 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 :

1. The licensee has failed to ensure that a residents' 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.

On a specific date, on a resident home area, Inspector #522 observed a medication cart unattended outside a resident’s room. The electronic Medication Assessment Record (eMAR) screen was open and resident personal health information was visible. A resident was standing in front of the medication cart and eMAR.

Inspector #522 noted the registered staff member was in a resident’s room with a resident and had their back to the door.

After five minutes, Registered Practical Nurse (RPN) #116 came out of the resident’s room and proceeded to administer medications to two other residents. At no point did RPN #116 close the eMAR screen when they were pushing the cart down the hallway or when they went into a resident’s room to administer medication.

In an interview, RPN #116 acknowledged they had left the eMAR screen open in the hallway when they went to administer medications. RPN #116 stated they did not always close the eMAR screen as they sometimes got busy and forgot.

To leave the eMAR screen open and unattended posed a potential risk for a breech of resident's personal health information.

Sources:
Observations of medication carts and eMARs and interviews with RPN #116 and RCC #115. [s. 3. (1) 11. iv.]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 25th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l’inspection :	2021_725522_0012
Log No. / No de registre :	009133-21, 009416-21, 010142-21, 010496-21, 011054-21, 012035-21, 013955-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 22, 2021
Licensee / Titulaire de permis :	County of Oxford 21 Reeve Street, Woodstock, ON, N4S-7Y3
LTC Home / Foyer de SLD :	Woodingford Lodge - Woodstock 300 Juliana Drive, Woodstock, ON, N4V-0A1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mark Dager

To County of Oxford, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (2).

Specifically,

A) Ensure that all drugs are administered to residents in accordance with the directions for use specified by the prescriber.
B) Complete and document retraining related to medication administration with Registered Practical Nurse #116.
C) Complete and document weekly audits of RPN #116 during medication administration to ensure RPN #116 is completing the "rights" of medication administration, hand hygiene and ensuring the medication cart and narcotic box are locked when unattended.
D) Audits shall be completed for 6 months or until compliance is achieved.
E) Keep documentation of corrective actions taken for any deficiencies found on the weekly audits.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents #010 and #011 in accordance with the directions for use specified by the prescriber.

A) A Critical Incident Systems (CIS) report was submitted to the Ministry of Long-Term Care related to a medication incident where Registered Practical Nurse (RPN) #116 administered the wrong dose of medication to resident #010.

Review of resident #010's electronic progress notes in Point Click Care (PCC) noted when resident #010 was administered the wrong dose of medication,

resident #010 had an adverse reaction.

In an interview, RPN #116 stated they were distracted by other residents when administering the medication to resident #010 and after they administered the medication and went to sign off in the electronic Medication Administration Record (eMAR) they noticed the error.

In an interview, the Manager of Resident Services (MRS) stated they followed up with RPN #116 after the RPN administered the wrong dose of medication to resident #010. The MRS reviewed their tracking documents and acknowledged RPN #116 had also administered the wrong dosage of medication to resident #011.

B) Review of CareRx Medication Incident/Near Miss Reports noted on two consecutive shifts RPN #116 administered the wrong dose of medication to resident #011.

Review of resident #011's progress notes noted there was no harm from either medication error.

In an interview, RPN #116 stated they were distracted on both dates and misread resident #011's orders in the eMAR.

In an interview, Resident Care Coordinator (RCC) #109 stated they spoke with RPN #116 after the medication errors with resident #011.

Sources:
Review of resident #010 and #011's clinical records, including eMAR and physician orders; CIS report #M632-000034-21; CareRx Medication Incident/Near Miss Reports; and interviews with RPN #116, RCC #109 and the MRS.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #010 after receiving an overdose of medication.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Scope: This noncompliance was widespread as RPN #116 made three medication errors in a one month period. RPN #116 made the same medication error with resident #011 two days in a row.

Compliance History: There was no previous noncompliance issued related to O. Reg. 79/10, s. 131. (2). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically,
A) Complete and document hand hygiene training with Registered Practical Nurse (RPN) #116.
B) Complete and document weekly audits of RPN #116's hand hygiene during medication administration.
C) Complete and document weekly audits of resident hand hygiene at snack and meal times and of staff entering the home during screening.
D) Audits shall be completed for 6 months or until compliance is achieved.
E) Keep documentation of corrective actions taken for any deficiencies found on the weekly audits.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) Observations of a meal service in a specific home area dining room noted a Personal Support Worker (PSW) student brought two residents into the dining room and assisted them to apply their clothing protectors. The residents were not assisted with hand hygiene prior to their meal.

In an interview, PSW #119 acknowledged that hand hygiene was not completed with residents prior to the meal. PSW #119 stated staff get busy and at times hand hygiene gets overlooked.

In an interview, the Manager of Resident Services (MRS) stated staff should go around in the dining room with hand sanitizer before meals to assist residents to

sanitize their hands.

B) On a specific date, Inspector #522 observed two staff members enter the home and be screened by Screener #111. Staff removed and disposed of their dirty surgical mask, took a clean surgical mask from a container on the screener's table, put on the clean surgical mask and walked away. At no point did either staff member sanitize their hands.

In an interview, Screener #111 stated they did not notice that the staff members did not sanitize their hands and did not realize they should monitor hand hygiene.

In an interview, MRS stated Screeners were expected to monitor staff and visitors entering the home to ensure that they were sanitizing their hands properly when they were removing their dirty mask and putting on a clean mask.

C) On a specific date, during observation of a medication pass, Inspector #522 observed Registered Practical Nurse (RPN) #116 administer medications to two residents without using hand hygiene.

In an interview, RPN #116 acknowledged they did not sanitize their hands when they administered the medications. RPN #116 stated they sanitized their hands when they gave an injectable medication or if they had to touch medication.

In an interview, Resident Care Coordinator (RCC) #115 stated registered staff should sanitize their hands before and after administering medications.

Review of the home's "Hand Hygiene" policy noted in part, that hand hygiene should be performed before preparing, handling, or serving food or medications to a resident; when in doubt; and staff should encourage residents to perform hand hygiene prior to eating.

Not following the home's "Hand Hygiene" policy put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources:
Review of the home's "Hand Hygiene" policy #2.02 with a review/revision date of

April 6, 2020; observations of the home's Infection Prevention and Control practices, including dining, screening and medication administration; and interviews with Screener #111, Screener #112 RPN #116, RCC #115, and the MRS

An order was made by taking the following factors into account:

Severity: There was actual risk to residents as during the inspection the home went into a respiratory outbreak.

Scope: This noncompliance was a pattern as a staff member was observed administering medication to residents without completing hand hygiene, residents did not have hand hygiene completed prior to meals and staff were observed not completing hand hygiene while donning and doffing their face mask.

Compliance History: There was no previous noncompliance issued related to O. Reg. 79/10, s. 229 (4). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 135. (1).

Specifically,

A) Ensure that medication incidents involving residents are documented, together with a record of the immediate actions taken to assess the resident.
B) Complete and document retraining with Registered Nurse #118 and Registered Practical Nurse #122 related to resident assessments after a medication incident, documentation of medication incidents and actions taken after a medication incident.

Grounds / Motifs :

1. The licensee has failed to ensure that medication incidents involving resident #011 were documented, together with a record of the immediate actions taken to assess resident #011 and was reported to the Medical Director and the prescriber of the drug.

A) Review of CareRx Medication Incident/Near Miss Reports noted on two consecutive shifts RPN #116 administered the wrong dose of medication to

resident #011.

Further review of CareRx's Medication Incident/Near Miss Reports for resident #011 noted the for the first medication incident the report did not include the specific incident type, contributing factors and follow up actions.
For the second medication incident the report did not include the type of incident and specific incident type, contributing factors, follow up actions and effect on the resident.

Review of resident #011's electronic clinical record in Point Click Care (PCC) noted no progress notes related to the medication incident, an assessment of the resident, vitals taken or follow up actions taken. There was no assessment of resident #011 documented until four days after the first medication incident, which was completed by Resident Care Coordinator (RCC) #109.

In an interview, Registered Nurse (RN) #118 stated they discovered the first medication incident. RN #118 stated they could not recall if they assessed resident #011 or took their vitals. RN #118 stated they would have documented the assessment in a progress note if they had completed one. RN #118 stated they did not inform RPN #116 of the medication incident.

In an interview, RPN #116 stated they were never informed of the first medication incident. RPN #116 acknowledged they made the same medication error the following shift and that they were informed of both errors several days later.

Registered staff did not document the medication incident involving resident #011 in the resident's progress notes and take action by informing RPN #116 of the medication incident, as per Woodingford and CareRx's policies, this put resident #011 at actual risk of harm as RPN #116 made the same medication error the following shift.

Sources:
Review of resident #011's clinical records; CareRx Medication Incident/Near Miss Reports, CareRx Medication Incidents policy #4.12 with a revision date of February 28, 2020; the home's Documentation & Reporting Incidents and Adverse Reactions policy #6.640 revised/reviewed September 1, 2020; Safe

Medication Administration Team Review Team minutes dated May 14, 2021; and interviews with RN #118, RPN #116, RCC #109 and the MRS.

An order was made by taking the following factors into account:

Severity: There was actual risk to resident #011 as an assessment was not completed and documented of the resident after receiving half the dose of their medication and registered staff did not inform the RPN who made the medication incident, resulting in the RPN making the same error the following shift.

Scope: This noncompliance was a pattern as two out of three medication incidents were not documented appropriately, including the assessment of the resident and actions taken.

Compliance History: There was no previous noncompliance issued related to O. Reg. 79/10, s. 135. (1). (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

Service Area Office /
Bureau régional de services : London Service Area Office