Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2014	2014_303563_0009	L-000389-14	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF OXFORD
300 Juliana Drive, WOODSTOCK, ON, N4V-0A1

Long-Term Care Home/Foyer de soins de longue durée

WOODINGFORD LODGE - WOODSTOCK
300 Juliana Drive, WOODSTOCK, ON, N4V-0A1

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

MELANIE NORTHEY (563), DONNA TIERNEY (569), PATRICIA VENTURA (517), RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 7, 2014 - April 11, April 14 - April 16, and April 22, 2014.

Concurrent inspections: L-000315-14 (IL-31792-LO) and L-000263-14 (M632-000004-14)

During the course of the inspection, the inspector(s) spoke with the Director, the Manager of Resident Services, the Supervisor of Food Service, the Registered Dietitian, the Coordinator of Resident Programs, the Coordinator of Resident Care: Lakewood/Pinecrest, the Coordinator of Resident Care: Mapleville/Peach Place, the Coordinator of Resident Care: Apple Grove/Orchard Lane, the Supervisor of Environmental Services, four family members, two Registered Nurses, 16 Registered Practical Nurses (RPN), 42 Residents, 23 Personal Support Workers (PSW), one Housekeeping Aide, one Cook, two Recreation Aides, and two Dietary Aides.

During the course of the inspection, the inspector(s) made observations, reviewed health records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A Bed Entrapment Inspection Audit was completed on April 25, 2013 and there was no documented evidence to support any actions were taken to address entrapment risk for those residents who failed the entrapment inspection.

The Manager of Resident Services shared that some of the mattresses were replaced and some bed rails were removed after the April 2013 audit, but could not confirm which beds. There was no retesting for bed entrapment for those beds that received a new mattress from the home's storage after the April 2013 audit. The Director confirmed there is no documented proof that the mattresses were replaced or bed rails removed for some of the beds that failed the entrapment audit on April 25, 2013.

Cardinal Health, an external vendor, conducted a mattress audit on October 2, 2013 where all existing mattresses were identified with a rating priority for mattress replacement. The Director confirmed her expectation is that those mattresses with a priority rating of "1" or any mattress measuring a length of 76 inches would be replaced. The Cardinal Health audit was inconsistent with the Bed Entrapment Audit.

The audits of three of the six home areas were reviewed by inspectors #563 and #128. Record review of the audits revealed 37 of the 80 beds failed the entrapment audit. Of the 37 beds that failed, 18 of those mattresses were not replaced and 3 of the 80 beds were not inspected for entrapment.

The Director revealed there was no follow up entrapment inspection for those beds with new mattresses supplied in April 2013 or in October 2013.

The Director confirmed the expectation is that there is immediate follow up with documentation and verbal reporting of all residents at risk for entrapment. The Director confirmed follow up from the April audit should have occurred immediately and documented. [s. 15. (1) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for Skin and Wound Care was complied with.

Registered staff did not follow instructions as per the Skin and Wound Care Program (policy number 6.382) upon discovery of a pressure ulcer.

The registered staff member verified she did not complete the follow up required upon discovery of a pressure ulcer as per the Skin and Wound Care Program (policy # 6.382). The registered staff failed to:

- Initiate a Wound Assessment Treatment Form (Form #NC-035)
- Stage the pressure ulcer using the staging guidelines on appendix C: Staging of Wounds)
- Communicate findings and recommendations to the Substitute Decision Maker (SDM)
- Ensure the plan of care was established outlining interventions and treatments
- Ensure the resident was on a turning and positioning schedule
- Obtain a seating assessment if the resident had an ulcer on a sitting surface
- Complete a pain assessment and refer to practitioner for effective management

- Participate in the weekly high risk rounds and take photographs of the wound as needed
- Complete the Wound Assessment and Treatment Form (Form #NC-035) weekly including size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used etc.
- Communicate with resident, SDM and the team (on the development and monitoring of plan of care, evaluation of progress, and reporting of the outcome)
- Identify the resident as being high risk for for pressure areas
- Place a pink sticker on the outer aspect of the leaf which is on the memory box found outside of the resident's room
- Attach a pink band to the mobility aid of the resident to prompt staff and family members to think about when the last time was that the resident was repositioned.
- Ensure all staff can identify the resident is at high risk for further skin breakdown, know whether, how and when the resident has been assessed, what the assessment results were, and the interventions and treatments being carried out.
- Make referrals to interdisciplinary team members as required (e.g. Nurse practitioner, registered dietitian, physiotherapist, occupational therapist)

The RPN verified that an open area to the coccyx would classify as a pressure ulcer and confirmed that follow up with the recommendations set forth on the Skin and Wound Care Program upon discovery of a pressure ulcer should have been done.

The Coordinator of Resident Care on the unit verified that registered staff received training in the staging of pressure ulcers and a form describing the stages of pressure ulcers was in the Treatment Administration Record binder and accessible to all the registered staff on the unit.

The Coordinator of Resident Care on the unit verified the expectation was that the recommendations written on the Skin and Wound Care Program (policy# 6.382) were followed upon discovery of a pressure ulcer. [s. 8. (1) (a),s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for Skin and Wound Care is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was kept clean and sanitary.

Observation of the servery floor between Peach Place and Mapleville resident home areas on April 15, 2014 revealed a build-up of black dirt on the floor.

A Dietary Aide and the Supervisor of Food Service indicated that there is a schedule to clean the floor and the floor's dirty condition did not meet the home's expectations. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home is maintained in a safe condition and in a good state of repair.

The hand rails in all six resident home areas were observed throughout the inspection and were noted to be rough, chipped and have splinters:

1. Orchard Lane observed by inspector #563
- outside room 217 near entrance to Orchard Lane;
- across from room 2S10;
- dining room, near fire doors #3;
- entire length of railing between 2S19 to 2S20;
- entire length of railing between 2S23 to 2S24;
- entire length of railing between 2S40 to 2S41;
- across from stairwell #2 outside fire doors #2.

2. Applegrove observed by inspector #563
- left handrail just inside the entrance;
- across from 2E04, and rail split at the corner;
- outside 2E38;
- entire length of railing between 2E19 to 2E29, both sides of the hall;
- across from room 2E16;
- outside room 2E41;
- outside room shower room, across from room 2E36.

3. Mapleville observed by inspector #569
- in the TV common area hallway;
- between 2N44 & 2N43;
- between 2N41 & 2N40 (closer to 2N41);
- between 2N32 & 2N 225;
- near the equipment storage door – outer corner.

4. Peach Place observed by inspector #569
- near door entrance rail on the left;
- left side rail at outer corner of TV lounge;
- 2W36 – outer corner and across the hallway;
- 2W28- outer corner; joint is separating;
- 2W27 – sharp outer corner and across the hall is very rough;
- between 2W22 & 2W25;
- out corner of hall leading to 2W22.

5. Pinecrest observed by inspector #517
- overall the handrails looked scratched and appeared to have been sanded in different parts as the color had worn off
- corner of handrail by activity room

- corner of handrail by room 1S45
- corner of handrail by room 1S40
- corner of handrail by the clean utility room (room 1S32)
- corner of handrail by the South stairwell

6. Lakewood observed by inspector #517
- overall the handrails looked scratched and appeared to have been sanded in different parts as the color had worn off
- corner of handrail by stairwell #1
- corner of handrail by room 1E47, 1E45, 1E38, 1E38, 1E37
- corner of handrail by equipment storage 1E32
- corner of handrail by soiled utility 1E26
- corner of handrail by room 1E27, 1E23 & 1E22
- corner of handrail by east stairs
- corners by the dining room patio door

The Environmental Services Supervisor shared on April 16, 2014 that he was not aware of the condition of the hand rails and acknowledged the potential risk to the fragile skin of residents. He indicated that this did not meet the maintenance expectations in terms of keeping the home in a good state of repair. [s. 15. (2) (c)]

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 home is kept clean and sanitary and that the home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system can be easily accessed and used by residents, staff and visitors at all times.

The resident indicated that the call bell was not accessible and requested inspector to place the call bell within reach. The call bell was observed to be on the bed and was approximately 5 feet from within the resident's reach. (128)

A PSW and a registered staff member stated the expectation is that call bells are always to be within reach of residents. (128)

A call bell was pressed at the bed side. The call bell did not activate the call bell system by light or sound 3 of the 5 attempts. (563)

Two seperate call bells were pressed at the bed side, it did not activate the call bell system by light or sound. (563)

Three PSWs confirmed the call bells were non-functional and followed up with the registered staff to have the call bells replaced immediately. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

The call bell in the washroom was pulled and was not answered by a PSW. A PSW acknowledged the signal was not activated to the pager. The registered staff confirmed the call bell had been activated and was not sounding to the pager and indicated that maintenance would be contacted immediately. [s. 17. (1) (f)]

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 resident-staff communication and response system is easily accessed and used by residents, staff and visitors at all times and is clearly indicated when activated where the signal was coming from, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including that the dining and snack service provided for monitoring of residents during meals.

A resident was observed eating unmonitored with the door closed in their room.

A PSW indicated that they were not required to monitor the unattended resident.

The Supervisor of Food Services and the Manager of Resident Services indicated that the expectation was that residents are monitored while eating in their rooms. They both acknowledged the potential risk and indicated that the home no longer had a policy to guide staff related to monitoring of residents during meals. [s. 30. (1) 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 there was a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including that the dining and snack service provided for monitoring of residents during meals, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu provided for a variety of foods each day from all food groups in keeping with Canada's Food Guide.

A review of the planned menu revealed that it did not provide for adequate servings of milk and alternatives. The menu provides for two servings of liquid milk for residents each day. Canada's Food Guide recommends that adults 51 plus years of age have three servings of milk and alternatives per day.

The Registered Dietitian approved the menu on March 28, 2014.

Interview with the Registered Dietitian revealed that some days cheese or yogurt are offered on the menu, but acknowledged that each day residents would not be offered the recommended three servings of milk and alternatives, according to Canada's Food Guide. [s. 71. (2) (b)]

2. The licensee failed to ensure that the planned menu items were offered and available at each meal.

1. Observation of the lunch meal revealed that the planned menu was not followed related to the amount of fluid being offered. The planned menu indicates that residents are to be offered 250 ml of coffee or tea. Two PSWs confirmed that each cup of coffee or tea is being recorded as one unit, equivalent to 250 millilitres (mls) in the fluid monitoring system. The cup was measured and noted to hold 180 mls fluid.

The Registered Dietitian acknowledged that the planned menu needed to be offered and what was recorded in the food and fluid monitoring system should match.

2. Pureed rice was not offered as per the planned menu. A Dietary Aide indicated that the pureed rice they were serving was not an appropriate texture so they changed it to mashed potatoes.

The Supervisor of Food Services acknowledged that the planned menu needed to be changed if menu items were not available. [s. 71. (4)]

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 menu provided for a variety of foods each day from all food groups in keeping with Canada's Food Guide and that the planned menu items were offered and available at each meal, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that food was served using methods which preserve taste, nutritive value, appearance and food quality.

At the lunch meal, 6/8 portion sizes (75%) were not served according to the planned menu which altered the nutritive value of the food. The following was noted:

- Regular Oriental Beef – 4 oz. portion served instead of 5 oz. portion;
- Ground Oriental Beef - #6 scoop served instead of #8 scoop;
- Pureed Oriental Beef - #6 scoop served instead of #8 scoop;
- Pureed whole wheat bread - #24 scoop used instead of #12 scoop;
- Ground pork schnitzel - #6 scoop instead of # 8 scoop;
- Pureed pork schnitzel - #6 scoop instead of #10.

The Supervisor of Food Services indicated that the expectation is that all food is served according to the posted serving sizes to ensure nutritive value is maintained. [s. 72. (3) (a)]

2. The licensee failed to ensure that food and fluids were prepared, stored and served using methods which prevent adulteration, contamination and food borne illness.

The dining room tables were observed set with drinking glasses on them. There were 12 glasses of pre-poured juice sitting on the tables. No staff were present in the dining room and four residents were observed touching and drinking out of the glasses on the table.

A PSW indicated that the glasses are usually set at that time.

The Director stated that there should not have been any food or fluids on tables unless a staff member was present and acknowledged the potential for contamination and directed the Dietary Aide to remove all the glasses of juice and re-pour them. [s. 72. (3) (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 that food was served using methods which preserve nutritive value and food quality, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food was served at a temperature that was palatable to the residents.

During lunch meal observations, interviews were conducted with residents to determine the palatability of the food. Two of eight residents (20%) interviewed expressed concerns that meals are not consistently served hot to residents.

Temperatures of food were taken as last resident was being served and it was noted that six of eight (75%) of the temperatures taken were below the required hot holding temperatures as noted on the temperature log for the home. The temperature log indicates the expectation is for hot food to be held at a minimum 60 degrees Celsius (140 degrees Fahrenheit). The following temperatures were noted:

Roast potatoes - 52 degrees Celsius
Pork Schnitzel - 43 degrees Celsius
Brussel Sprouts - 42 degrees Celsius
Sunrise Mixed Vegetables - 46 degrees Celsius
Pureed Pork - 40 degrees Celsius
Ground Brussel Sprouts - 50 degrees Celsius

A Dietary Aide and the Supervisor of Food Services acknowledged that this did not meet the expectation of the home as hot food was to be served hot. The Supervisor of Food Services indicated that the last resident served is expected to have hot food the same as the first resident served. [s. 73. (1) 6.]

2. The licensee failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.
A
PSW was observed assisting a resident to drink thickened fluids. The PSW was not using proper techniques to assist the resident. The PSW was sitting on the arm of a comfortable chair and was observed to be seated approximately 15 inches above the resident's eye level. The resident was noted to be at a 75 - 80 degree angle.

The PSW indicated that the resident was on thickened fluids related to risk of choking. After acknowledging that the expectation was to be seated at eye level and that he/she was not at the correct height, he/she changed position to be at eye level with the resident.

The Resident was heard coughing twice, post the thickened fluids being given at a unsafe position. [s. 73. (1) 10.]

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 food was served at a temperature that was palatable to the residents and that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

An unlocked and unattended treatment cart, containing prescription creams and lotions, was observed in the Lakewood documentation room at 0815 hrs. on April 16, 2014.

The Resident Services Manager acknowledged the potential risk and indicated that the expectation is that prescription creams should be locked and not accessible to residents. [s. 129. (1) (a) (ii)]

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 drugs were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #10: 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).

Findings/Faits saillants :

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

Unlabeled and improperly stored personal care equipment was observed in shared resident washrooms.

The Director indicated that the expectation is that all personal care equipment should be labeled with the resident's name and any creams and lotions should be labeled with the resident's name on it after the first use. (128)

The Director also indicated that catheter bags should be labeled with the resident's name and/or placed in a caddy and all catheter bags are to be rinsed and absent of any urine. (128)

Observation of the tub room in Applegrove resident home area revealed one bottle of body lotion used and unlabeled and one spray bottle of body mist used and unlabeled. (563)

Observation of the shower room in Applegrove resident home area revealed one jar of petroleum jelly used and unlabeled, one bottle of body lotion used and unlabeled and one bottle of mouthwash used and unlabeled. (563)

Observation of the shower room in Orchard Lane resident home area revealed the shower room had one comb unlabeled, one jar of petroleum jelly used and unlabeled and one tube of lubricating jelly used and unlabeled. [s. 229. (4)]

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

The lower cabinet door in the Special Events Room (room 105 in the main level) was unlocked with multiple large kitchen knives inside. The door to the Special Events Room was opened and residents had access to this room.

The Manager of Resident Services and the Coordinator of Resident Programs confirmed the large kitchen knives posed a safety risk for the residents and the cabinet door should have been locked. [s. 5.]

WN #12: 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 failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident with regard to recreational activities.

The last quarterly Recreational Assessment for this resident identified that this resident enjoyed and would like to participate in several recreational activities.

The electronic care plan for this resident in Point Click Care available to the direct care staff on the unit did not indicate the resident enjoyed and would like to participate in these activities. The resident's plan of care available to PSWs in Point of Care did not indicate this resident enjoyed and would like to participate in these activities.

The recreation staff confirmed that direct care staff on the unit did not have clear direction as to the activities this resident would enjoy and would like to participate in as identified on the resident's most recent Recreational Assessment. The recreation staff confirmed the expectation was that all direct care staff have clear direction on what recreational activities residents would enjoy and would like to participate in. [s. 6. (1) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with food and fluids that are safe.

Lunch observations revealed that the asparagus served was not a safe texture for those residents on ground diets. The pieces of asparagus were approximately 3 cm in length.

The home's policy #5.338 dated October 29, 2013, entitled Overview of Nutrition and Hydration Program and Interventions, indicated that foods on the ground texture should require little or no chewing and should be minced, finely chopped, mashed, soft or finely grated.

The Supervisor of Food Services shared that the asparagus was not a safe texture to be served on a ground diet and acknowledged the potential choking risk. [s. 11. (2)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The Manager of Resident Services shared that the home only held one meeting in November 2013. [s. 59. (7) (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the inspection reports from the past two years in the long term care home were posted in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

Inspection reports for January 14, 2014 and February 13, 2014 were posted in the home's main lobby in the designated area for Ministry of Health and Long Term Care inspection reports.

Inspection reports for February 28, 2012 and June 20, 2013 were not posted.

The Assistant Administrator confirmed not all inspection reports were posted as required. [s. 79. (3) (k)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident's written record was kept up to date at all times.

Observations revealed a resident did not wear dentures.

A clinical record review revealed that Minimum Data Set Assessment and plan of care indicated that the resident has top and bottom dentures and staff are to provide assistance with cleaning the dentures.

Two Personal Support Workers and the Coordinator of Resident Care shared that the resident does not wear dentures.

Record review of the progress notes revealed that the resident has not worn dentures since 2012.

The Coordinator of Resident Care indicated that the expectation was that the assessment and the plan of care was kept up to date at all times and confirmed that it had not been for this resident. [s. 231. (b)]

Issued on this 28th day of May, 2014

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

Melanie Northey

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), DONNA TIERNEY (569), PATRICIA VENTURA (517), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2014_303563_0009
Log No. / Registre no:	L-000389-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 6, 2014
Licensee / Titulaire de permis :	COUNTY OF OXFORD 300 Juliana Drive, WOODSTOCK, ON, N4V-0A1
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 :	CORRIE FRANSEN

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 Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must take immediate action to achieve compliance to ensure when bed rails are used,
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. O.Reg. 79/10, s. 15. (1) (b)

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s. 15. (1) (b).

The plan must include immediate and long-term actions to be implemented to ensure all resident beds pass all zones of entrapment, as well as actions taken to correct the identified deficiencies, who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Melanie Northey, Long-Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email to Melanie.Northey@Ontario.ca by May 14, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A Bed Entrapment Inspection Audit was completed on April 25, 2013 and there was no documented evidence to support any actions were taken to address entrapment risk for those residents who failed the entrapment inspection.

The Manager of Resident Services shared that some of the mattresses were replaced and some bed rails were removed after the April 2013 audit, but could not confirm which beds. There was no retesting for bed entrapment for those beds that received a new mattress from the home's storage after the April 2013 audit. The Director confirmed there is no documented proof that the mattresses were replaced or bed rails removed for on some of the beds that failed the entrapment audit on April 25, 2013.

[redacted]

Cardinal Health, an external vendor, conducted a mattress audit on October 2, 2013 where all existing mattresses were identified with a rating priority for mattress replacement. The Director confirmed her expectation is that those mattresses with a priority rating of "1" or any mattress measuring a length of 76 inches would be replaced. The Cardinal Health audit was inconsistent with the Bed Entrapment Audit.

The audits of three of the six home areas were reviewed by inspectors #563 and #128. Record review of the audits revealed 37 of the 80 beds failed the entrapment audit. Of the 37 beds that failed, 18 of those mattresses were not replaced and 3 of the 80 beds [redacted] were not inspected for entrapment.

[redacted]

The Director confirmed the expectation is that there is immediate follow up with documentation and verbal reporting of all residents at risk for entrapment. The Director confirmed follow up from the April audit should have occurred immediately and documented.
(563)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 11, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Melanie Northey

Name of Inspector / Nom de l'inspecteur : Melanie Northey

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