Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2019	2018_648741_0002	003906-18	Critical Incident System

Licensee/Titulaire de permis

County of Oxford
21 Reeve Street WOODSTOCK ON N4S 7Y3

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

Woodingford Lodge - Ingersoll
325 Thames Street South INGERSOLL ON N5C 2T8

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

AYESHA SARATHY (741), HELENE DESABRAIS (615)

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): December 19 and 20, 2018.

The following Critical Incident (CI) report # M614-000002-18/Log #003906-18 was inspected during the course of this inspection related to prevention of falls.

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Services, a Registered Nurse Manager, a Registered Nurse and a Personal Support Worker.

During the course of the inspection, the inspector(s) also reviewed medical records and plans of care for identified residents, reviewed relevant policies and procedures of the home and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The Licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital and that resulted in a significant change in the resident's health condition.

a) A Critical Incident (CI) report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) related to the fall and change in condition of an identified resident. The identified resident's clinical record was reviewed, which stated that the resident sustained a fall. Their Power of Attorney (POA) was notified and they were sent to the hospital.

The following day, a staff member called the resident's POA to review their status and the POA said that the resident had sustained multiple injuries.

When the resident returned back to the home, they were too lethargic to eat and their best speech was described as moaning on movement. They remained lethargic the next day and were noted to have pain on movement.

A review of the resident's clinical records indicated that the resident had a significant change in their mobility status.

During interviews, a Personal Support Worker (PSW), the Registered Nurse Manager (RNM) and the Manager of Resident Services (MRS) said that there was a significant change in the resident's health condition from the fall. The MRS said that it would be the home's expectation to report this incident to the Director within one business day.

The licensee failed to ensure that the Director of the Ministry of Health and Long-Term Care was informed no later than one business day after the occurrence of the identified resident's fall for which they were taken to the hospital and that resulted in a significant change in their health condition. [s. 107. (3) 4.]

b) An identified resident's clinical records were reviewed as they were inspected as a part of a critical incident related to another resident.

The clinical records stated that the resident sustained a fall and was found on the floor in

their room by staff. Bruising and swelling was evident at the time of the fall. The next day the resident was very anxious and complained of pain. They were then sent to the hospital. The bruising and swelling continued the next day and the resident now required assistance with their care. Prior to the fall the resident was independent with their own care.

The RNM, a Registered Nurse (RN) and a PSW said during interviews that the resident had a fall and that there was a significant change in their condition and they were sent to the hospital. In another interview, the MRS said that the MRS at that time did not submit a Critical Incident for this incident and that it would be the home's expectation to report this to the Director. [s. 107. (3) 4.]

c) An identified resident's clinical records were reviewed as they were inspected as a part of a critical incident related to another resident.

The clinical records indicated that the resident sustained a fall and was found on the floor in their room by staff.

The resident sustained another fall on a different date and was found on the floor in their room by staff. The resident complained of pain and weakness and was sent to the hospital the following day. Upon return from the hospital, the resident's health condition had significantly changed.

During interviews, the RNM, an RN and a PSW said that the resident had a fall for which they were sent to the hospital and resulted in a significant change in their health condition. In another interview, the MRS said that the MRS at that time did not submit a Critical Incident for this incident and it would be the home's expectation to report this to the Director.

The licensee failed to ensure that the Director of the Ministry of Health and Long-Term Care was informed no later than one business day after the occurrence of the identified residents' fall for which they were taken to the hospital and that resulted in a significant change in health condition.

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 Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital and that resulted in a significant change in the resident's health condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The home submitted a Critical Incident (CI) to the Ministry of Health and Long Term Care (MOHLTC) related to the fall and change in condition of an identified resident. The resident's clinical record showed that they had a history of falls and were at high risk for falling.

During interviews, PSW and RNM stated that resident had a trigger for falls which may have caused this fall. RNM reviewed the resident's care plan during the interview and said that the trigger was not included in the resident's care plan and that the resident care plan did not reflect the resident's needs at that time.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

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Issued on this 18th day of January, 2019

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

Original report signed by the inspector.