Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Original Public Report

Report Issue Date: November 7, 2022	
Inspection Number: 2022-1609-0001	
Inspection Type: Critical Incident System	
Licensee: County of Oxford	
Long Term Care Home and City: Woodingford Lodge - Ingersoll, Ingersoll	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2022.11.14 08:31:21 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 1, 2 and 3, 2022.

The following intake(s) were inspected:

- Intake: #00001085 - [CI: M614-000008-22] related to the fall prevention and management program
- Intake: #00005768 - [CI: M614-000002-22] related to allegations of resident neglect.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident's care needs changed after a fall with injury.

Rationale and Summary:
A critical incident documented that a resident had an unwitnessed fall resulting in an injury and a significant change in their health status.

Review of the resident's progress notes and care plan in PointClickCare (PCC) showed that the resident's care plan had not been updated after there was a significant change in status related to transferring, ambulation and toileting.

A Personal Support Worker (PSW) said they would find information related to a resident's care needs on the Kardex care plan on Point of Care or care card in the resident's bathroom. A Registered Practical Nurse (RPN) and PSW both said that the resident's care needs had changed after the fall and had required total assistance with care including the use of personal assistance service devices for ambulation and all transfers.

Manager/Director of Care (MDOC) reviewed the care plan and said that the care plan should have been updated after there was a significant change in status, and it was not. This placed the resident at risk for not receiving the interventions they needed.

Sources: Critical Incident System report; resident's clinical records; and interviews with a PSW, RPN and MDOC.

WRITTEN NOTIFICATION: Personal Assistance Service Device (PASD)

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)

The licensee has failed to ensure that a personal assistance service device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Rationale and Summary:
A critical incident documented that a resident had an unwitnessed fall resulting in an injury and a significant change in their health status.

Progress notes documented the use of a specific personal assistance service device (PASD) on multiple occasions. In addition, a fall incident note documented that the resident was found sitting on the PASD. The staff had witnessed the PASD flip forward, and the resident had fallen to the floor. The resident was complaining of an injury.

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) both confirmed the resident used the PASD. RPN said that the resident began using the PASD for comfort and healing after the fall.

The resident's clinical record did not include an interdisciplinary assessment for the PASD and there was no focus, goals or interventions, noted in the plan of care for the use of the PASD.

The home's policy titled "Restraints Minimization: Use of Personal Service Devices (PASDs)" stated that the "resident's care plan must indicate how, when and why the device is to be used" and that "intervention descriptions will include how the PASD will be used, when, how long, who will apply and remove, frequency of monitoring, and the specific risks associated (e.g. skin breakdown)." In addition, the assessment was to be carried out collaboratively by an interdisciplinary team.

The Manager/Director of Care (MDOC) said that the resident's specific device was a PASD. The MDOC confirmed the expectation that an assessment of the resident was completed prior to the use of a PASD and that the plan of care be updated to include the use of the PASD. There was a risk of injury to the resident as a result of implementing the specific PASD for them without an interdisciplinary assessment.

Sources: Critical Incident System report; resident's clinical records; the home's policy titled "Restraints Minimization: Use of Personal Assistance Service Devices (PASDs)" Number: 6.090 Revised July 4, 2022; and interviews with a PSW, RPN and MDOC.

WRITTEN NOTIFICATION: Continence Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)

The licensee has failed to ensure that continence products were not used as an alternative to providing assistance to a resident to toilet.

Rationale and Summary:

Review of a critical incident documented that a resident was admitted to the home accompanied by a family member. The family member reported that the resident had rang the call bell as they needed to go to the bathroom. A Personal Support Worker (PSW) had entered the resident's room and when the resident requested to void, the PSW told the resident that they had a product on, so they could just go in their briefs. The PSW said that they would clean the resident up later and then left the room. The family member stated that they had witnessed the interaction and had felt uncomfortable with the situation.

Record review of the care plan documented the resident required extensive assistance with toileting related to a specific diagnosis. This was confirmed by a PSW. Review of an employee letter documented that a PSW had agreed that the situation had happened and had told the resident they had a product on and that they could go to the bathroom in their brief. The resident was upset by the response as their request had been denied.

The MDOC confirmed it was the home's expectation that staff should have assisted the resident at the time of the request. This placed the resident at potential risk for altered skin integrity.

Sources: Critical Incident System report; resident's clinical records; and interviews with the MDOC and a PSW.

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