Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 23, 2024	
Inspection Number: 2024-1609-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: County of Oxford	
Long Term Care Home and City: Woodingford Lodge - Ingersoll, Ingersoll	
Lead Inspector Cheryl McFadden (745)	**Inspector Digital Signature**
Additional Inspector(s) Julie Lampman (522) Kristen Murray (731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 13, 14, 15, 20, 21, 2024
The following intake(s) were inspected:

- Intake: #00108638 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and

The licensee has failed to ensure that the home's "Resident Abuse - Zero Tolerance for Abuse and Neglect" policy was in compliance with and implemented in accordance with all applicable requirements under the Act.

Rationale and Summary
FLCTA 2021 s. 25 (1) states, "every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents."

FLCTA 2021 s. 25 (2) states, "at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 28 to make mandatory reports."

The home's "Resident Abuse - Zero Tolerance for Abuse and Neglect" policy referenced the duty to make mandatory reports as per the Long-Term Care Homes Act (LTCHA) 2007, s. 24 (1), instead of the Fixing Long-Term Care Act (FLTCA) 2021, s. 28 (1).

The policy indicated that the home would report and submit all mandatory and critical incidents to the Ministry of Health and Long-Term Care (MOHLTC), instead of the Ministry of Long-Term Care (MLTC) and that the MOHLTC Director was to be informed immediately of abuse and neglect of a resident. The policy also referenced reporting critical incidents under Ontario Regulation (O. Reg) 79/10 s. 107 instead of O. Reg 246/22 s. 115.

The Manager reviewed the policy with Inspector #522 and acknowledged that they had not been updated with the current legislative references and that the Ministry name was not correct. The Manager updated the policy and referenced FLTCA 2021, O. Reg 246/22 and the MLTC.

Sources:
Review of the home's "Resident Abuse - Zero Tolerance for Abuse and Neglect" policy I 6.045, reviewed/revised January 2023, the home's "Resident Abuse - Zero

Tolerance for Abuse and Neglect" policy I 6.045, reviewed/revised February 2024, and an interview with the Manager. [522]

Date Remedy Implemented: February 15, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

Non-Compliance was found during this inspection and was remedied by the Licensee prior to the conclusion of the inspection. The Inspector was satisfied that the non-compliance met the intent of O. Reg. 246/22, s. 102 (7) 11 and requires no further action.

The licensee has failed to ensure that the home's hand hygiene program included at a minimum access to hand hygiene agents at point-of-care.

Rationale and Summary
On February 14, 2024, at 1148 am, inspector #745 observed 17 resident rooms that did not contain ABHR at point of care.

Review of Policy 1 2.02 titled "Hand Hygiene" included Alcohol-based hand rub

dispensers should be placed at entrances, point-of-care locations, common spaces, and dining rooms.

A resident stated the sanitizer had been removed from their room and they thought it was no longer required. Interview with IPAC Lead confirmed there was no ABHR in the 17 identified rooms, that it had been removed in error prior to the installation of new wall mounted sanitizer pumps. They confirmed ABHR should be in each room at the point of care.

On February 14, 2024, at 1257, inspector #522 observed all rooms had ABHR available at point of care.

Sources: Observations, Policy 1 2.02 titled “Hand Hygiene and interviews with a resident and IPAC Lead.

Date Remedy implemented: February 14, 2024

[745]