Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 23, 2010	2010_105_9614_23Aug092838	CI M614-000011-10 L-00514

Licensee/Titulaire
County of Oxford 325 Thames St. S. Ingersoll ON N5C 2T8

Long-Term Care Home/Foyer de soins de longue durée
Woodingford Lodge-Ingersoll 325 Thames St. S. Ingersoll ON N5C 2T8

Name of Inspector(s)/Nom de l'inspecteur(s)
June Osborn #105

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector spoke with the Charge RN, the resident, and the assistant manager of operations/resident services from the Tillsonburg home (covering for Ingersoll home).

During the course of the inspection, the inspector observed the bed, a re-enactment of how the resident was found, reviewed the plan of care, reviewed for post fall assessment, reviewed policies concerning bed rails.

The following Inspection Protocols were used in part or in whole during this inspection:
Safe and Secure Home (bed rail section).

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.
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.)	Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg.79/10 s.15(1)(a).
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.

Findings:

1. There is no evidence-based process when bedrails are used to assess residents and their bed system to minimize risk to the resident.

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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 by establishing an evidence-based process to minimize the risk to residents when bedrails are used , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg.79/10 s.15(1)(b).
Every licensee of a long-term care home shall ensure that where bed rails are used,
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Findings:
1. There is no process in place to prevent resident entrapment.

Inspector ID #:	#105

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 ensuring steps are taken to prevent resident entrapment , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg.79/10 s.15(1)(c).
Every licensee of a long-term care home shall ensure that where bed rails are used,
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Findings:
1. There is no evidence that safety issues such as latch reliability are being addressed.

Inspector ID #:	#105

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 ensuring other safety issues related to bed rails are addressed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg.79/10 s.48(1)(1).
Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Findings:
1. There is no Falls Prevention and Management program in place.

Inspector ID #:	#105

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 by ensuring a Falls Prevention and Management program is in place, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** June Abbas #105
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). August 25/10