Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Mar 5, 2020	2020_536745_0008	002691-20, 002834-20	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 - Woodstock
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

CHERYL MCFADDEN (745)

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): February 20, 21, 24 and 27, 2020.

The following intakes were completed within the Critical Incident Inspection:
Log# 002691-20 / CI# M632-000006-20 related to prevention of abuse and neglect.
Log# 002834-20 / CI# M632-000007-20 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurse (RN), Registered Nurse, Behavior Supports Ontario (BSO), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Personal Support Worker, Behavior Supports Ontario (BSO).
The inspector reviewed relevant clinical records, plans of care, relevant policies and observed identified residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that identified residents were protected from abuse by anyone.

Ontario Regulation 79/10, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), any use of physical force by anyone other than a resident that causes physical injury or pain, or (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident;

The home submitted several Critical Incident System (CIS) reports to the Ministry of Long-Term Care (MLTC) on specified dates, related to physical altercations between identified residents.

A. The CIS report stated that an identified resident was physically aggressive towards another identified resident and the other resident sustained injuries from this incident.

Review of the Woodingford Lodge policy titled “Resident Abuse-Zero Tolerance for Abuse and Neglect” revised October 2019, stated the following:
“Woodingford Lodge is committed to a zero tolerance of abuse or neglect of its residents whereby”
-“residents are free from abuse”
-“no resident is required to tolerate any type of abuse from another”

The progress notes and care plan for this resident documented specific details about the incident and responsive behaviour's interventions in place for this resident.

During an interview with a specific staff member they said they were aware of an incident between the identified resident and another resident. They stated the identified resident did have responsive behaviour's and was on constant Dementia Observation System (DOS) charting and was a risk to other residents.

During an interview with another staff member they said an identified resident was sent to hospital after this incident due to injuries.

During an interview with the Director of Care (DOC), they said the home had submitted a CIS report to the MLTC, related to this incident between identified residents and the injuries sustained.

B. The home submitted a Critical Incident System (CIS) report to the MLTC on a specified date. The CIS report stated that the same identified resident had an incident and injured another resident.

The progress notes for this resident documented specific details about this incident, including details related to the injuries sustained.

During an interview the registered staff member said they witnessed the incident and intervened.

During an interview with another registered nursing staff, they said they were familiar with an incident between the identified resident and another resident. They stated the identified resident had responsive behaviours and was a risk to other residents.

The licensee failed to ensure that the identified residents were protected from abuse by anyone. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff,, to be implemented voluntarily.

Issued on this 5th day of March, 2020

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

Original report signed by the inspector.