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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 24, 2023	
Original Report Issue Date: May 18, 2023	
Inspection Number: 2023-1627-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: County of Oxford	
Long Term Care Home and City: Woodingford Lodge - Woodstock,Woodstock	
Amended By Ina Reynolds (524)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to correct a date within the report in Written Notification NC #002.

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Lead Inspector Ina Reynolds (524)	**Additional Inspector(s)** Tatiana Pyper (733564)
Amended By Ina Reynolds (524)	**Inspector who Amended Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.05.24 14:23:05 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to correct a date within the report in Written Notification NC #002.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 10, 11, 12, 2023.

The following intake(s) were inspected:
- Intake #00002198 CI #M632-000034-22 related to safe lifts and transfers
- Intake #00006783 CI #M632-000016-22 related to prevention of abuse and responsive behaviours
- Intake #00017334 CI #M632-000001-23 related to prevention of abuse and responsive behaviours
- Intake #00019894 CI #M632-000005-23 related to falls prevention and management
- Intake #00021337 a complaint related to medication administration and management
- Intake #00022817 a complaint related to resident care and support services

- Intake #00085087 CI #M632-000012-23 related to resident care and support services.

The following intake(s) were completed in this inspection:
- Intake #00003883 CI #M632-000031-22 related to falls prevention and management
- Intake #00006233 CI #M632-000003-22 related to falls prevention and management
- Intake #00007182 CI #M632-000010-22 related to falls prevention and management
- Intake #00010903 CI #M632-000044-22 related to falls prevention and management
- Intake #00011924 CI #M632-000045-22 related to falls prevention and management
- Intake #00012147 CI #M632-000047-22 related to falls prevention and management
- Intake #00012336 CI #M632-000049-22 related to falls prevention and management
- Intake #00012568 CI #M632-000050-22 related to falls prevention and management
- Intake #00018722 CI #M632-000004-23 related to falls prevention and management
- Intake #00020207 CI #M632-000006-23 related to falls prevention and management
- Intake #00021713 CI #M632-000009-23 related to resident care and support services.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED 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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed.

A Critical Incident System (CIS) report documented that a resident had a significant change in their

health status. The resident was diagnosed with a specific injury and after treatment, the resident returned to the home.

Review of the resident's care plan and care guide showed the resident utilized a specific transfer aid.

Observation and interview with a staff member showed the resident's specific transfer aid was different than what was noted in the care plan and care guide. A staff member said that the transfer aid had changed.

A Supervisor of Resident Care (SRC) acknowledged the transfer aid had changed, and the care plan was updated with the required intervention. There was low risk to the resident at the time of the observation.

Sources: A Critical Incident; a resident's clinical records; and interviews with a SRC and a staff member.

Date Remedy Implemented: May 10, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the written plan of care for a resident was provided as specified in the plan related to dressing and personal hygiene.

Rationale and Summary:

An anonymous complaint was received by the Director related to dressing and personal hygiene for a resident.

1. A resident's plan of care noted that they required assistance with dressing, and they were to be appropriately dressed. A progress note indicated the resident was upset and had called their family member as they were not appropriately dressed.

The Manager of Resident Services stated that the resident not being dressed appropriately on that day, did not meet the expectations of the home. Residents not appropriately dressed during the day could have had a negative impact on their quality of life.

2. A resident's plan of care indicated that they were not to have a specific personal hygiene task completed by staff in the home, as per resident's power of attorney's preferences and was to be completed by a family member.

Review of the documentation for the resident noted that this task was completed by staff on multiple days.

The Manager of Resident Services stated that the resident's personal hygiene task completed by staff, did not respect the resident's wishes.

Sources: Review of the resident's clinical records, and interview with the Manager of Resident Services.

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Woodingford Lodge Woodstock Head Injury Protocol Policy was complied with as a part of the Falls Prevention and Management Program.

Specifically, staff did not comply with the licensee's Head Injury Management Policy that was part of the licensee's Falls Prevention and Management Program which stated that a head injury routine would be initiated when a resident received an injury to the head, acquired a suspected injury to the head, or had an unwitnessed fall.

Rationale and Summary:

A Critical Incident System (CIS) report was submitted to the Director as a result of a resident's unwitnessed altercation with another resident in the home. According to the CIS report, the altercation between the two residents resulted in a suspected head injury for a resident. The CIS noted that an HIR was initiated as per the Head Injury Management Policy of the home.

Review of the clinical records for the resident, noted that the HIR documentation was not completed at several times during the intervals of times required. The clinical records indicated that a neurological assessment for the resident was not fully completed, including, an assessment of their blood pressure, pulse, pupils, and level of consciousness post head injury, and the documentation indicated either "sleeping" or "confused".

The home's Head Injury Management Policy indicated that when a resident was suspected of having

sustained a head injury, a nursing assessment and intervention was to be initiated. The policy further indicated that neurological assessments were to be completed every thirty minutes for two hours, every one hour for two hours, then resident was to be roused every two hours for an assessment of their level of consciousness and orientation with a full assessment every four hours for twenty hours.

The Manager of Resident Services and a Registered Practical Nurse stated that the HIR was not completed in full at the time intervals required, as per the home's Head Injury Management Policy.

There was risk to the resident when they were not neurologically assessed for changes in their level of consciousness or responsiveness for several of the required time periods.

Sources: The Woodingford Lodge Woodstock's Head Injury Protocol Policy #6.430, a resident's clinical records, interview with the Manager of Resident Services and a Registered Practical Nurse.