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

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Original Public Report

Report Issue Date: September 20, 2024
Inspection Number: 2024-1627-0004
Inspection Type: Complaint Critical Incident
Licensee: County of Oxford
Long Term Care Home and City: Woodingford Lodge - Woodstock, Woodstock

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 27-29 and September 3-6, 9, 10 and 12, 2024

The following intakes were inspected:

- Intake: #00124168 - CIS: M632-000052-24 - Related to falls prevention and management
- Intake: #00124467 - Complaint related to resident care and support services
- Intake: #00124611 - CIS: M632-000054-24 - Related to resident care and support services

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control

Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: When Reassessment, Revision is Required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Rationale and Summary:

There was a change to a resident's care needs which included a specific intervention. During staff interviews, it was not clear to the staff who was responsible for that care of that intervention.

The resident's care plan did not include a reference to the intervention, nor was there a Treatment Administration Record (TAR) or a task in Point of Care (POC) for the intervention.

Staff reported that a task should have been created for the intervention when the resident's care needs changed.

As a result of not updating the plan of care when the resident's care needs changed, the plan of care was not clear to the staff, which may have impacted the resident's care.

Sources: Resident's progress notes, TARs, tasks, Care Plan, observations and interviews with staff.

WRITTEN NOTIFICATION: Air Temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that air temperatures in the home were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in the areas required under Ontario Regulation (O. Reg.) 246/22 subsection two.

Rationale and Summary:
O. Reg. 246/22 section 24, subsection two states that every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home: at least two resident bedrooms in different parts of the home, and one resident common area on every

floor of the home, which may include a lounge, dining area or corridor.

Upon review of the homes air temperature logs it was identified that there were 25 shifts over a two-month period where the air temperatures were not completed and documented for the required home areas.

Staff acknowledged that the air temperature logs were not being audited to identify gaps in the home's process.

In addition, the home was using an infrared thermometer for the air temperature checks. Staff reported that the thermometer was for checking surface temperatures, which was verified with the thermometers manufacturer's instructions.

As a result of not ensuring the air temperature logs were completed as required and not utilizing a best practice process to ensure that a thermometer that measured air temperatures was used, there was risk that the home did not obtain accurate readings of the air temperatures in the home.

Sources: Air Temperature logs, manufacturer instructions and interviews with staff.

WRITTEN NOTIFICATION: Menu Planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,

(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the menu cycle was approved for nutritional adequacy by a registered dietitian (RD) prior to being in effect.

Rationale and Summary:
Staff reported that a new menu cycle was implemented in the home on a specified date.

Although the menu cycle was reviewed by the RD prior to the implementation of the menu cycle, the home had not received a copy of the approval from the RD until four weeks after implementing the menu cycle.

There was risk that by not having a process in place to ensure that the menu cycle was approved by the RD prior to being implemented, that the nutritional adequacy of the menu would not meet the needs of the residents.

Sources: Tool for Menu Approval and Review, Woodingford Lodge and interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that the treatment ordered for a resident was administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
A resident was prescribed a treatment, which was to be applied at specific times.

Although the order was processed and included on the resident's Medication Administration Record (MAR), a task was not completed in POC by the staff who processed the order, as was expected.

As a result of not following the home's process for completing the order, the resident's treatment did not get administered as required.

Sources: Resident's orders, MARs, POC tasks, and interview with staff.