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
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Original Public Report

Report Issue Date: May 1, 2024	
Inspection Number: 2024-1610-0001	
Inspection Type: Complaint	
Licensee: County of Oxford	
Long Term Care Home and City: Woodingford Lodge - Tillsonburg, Tillsonburg	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2024.05.02 13:41:22 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred offsite on the following date(s): April 22, 2024.

The following intake(s) were inspected:

- Intake: #00111811 complaint related to Resident Discharge.

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

Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Discharge

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

Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)

When licensee may discharge

s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,

(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure they were informed by the physician or a registered nurse in the extended class attending to a resident who was absent from the home, before discharging the resident.

Ontario Regulation 246/22 s. 157 (1) states, a licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

Rationale and Summary

This inspection was initiated as a result of complaint received by the Ministry of Long-Term, regarding a resident's discharge from the home.

A representative from Home and Community Care Support Services (HCCSS) Southwest, complained they had received a discharge letter for a resident and a vacancy for their bed, but the resident was absent from the home. The home said they were not able to meet the needs of the individual. A care conference had

happened, but the home was firm in their decision to continue with the discharge of the resident despite not following protocol or recommendations.

A review of the resident's records showed the resident was discharged from the home while absent from the home. A discharge letter from the home's Administrator was sent to the HCCSS and the resident's Substitute Decision Maker. The home provided a description of what had happened since admission and that the resident had been involved in numerous incidents.

The home, however, did not have documentation from the resident's attending physician informing the licensee that the requirements for care had changed, as required to support the discharge of the resident.

The Administrator acknowledged that the discharge was done by the home's Director and Medical Director while the resident was absent from the home and the home was not informed by the physician or a registered nurse in the extended class attending to the resident while absent from the home.

Sources: Complaint record, health care record for the resident, and staff interviews. [524]