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
Jun 10, 2021	2021_607523_0012	007914-21	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 - Ingersoll
325 Thames Street South Ingersoll ON N5C 2T8

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

ALI NASSER (523)

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): June 7 and 8, 2021.

This inspection was completed for Critical Incident Intake Log #007914-21, related to a resident's fall.

Inspectors Angela Finlay and Catherine Ochnik were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/DOC, Maintenance Supervisor, Housekeeping staff member, two Public Health Inspectors, Two Personal Support Workers, a Registered Nurse and one resident.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (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. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that air temperatures of the home were measured and documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Observations during the inspection on a specific resident home area showed air temperatures of 26 and 27 degrees Celsius.

In an interview the Maintenance Supervisor said they reviewed the home's temperature through the automated system once a day. They said there was no documented record of the air temperatures. They were not aware of the requirement to measure and document the air temperatures of the home on different locations in the home and at specific intervals.

In an interview, the Administrator/DOC said they were not aware the legislative requirement for indoor temperature was to be monitored at minimum three times daily at specified times and in specified areas of the home.
At the time of the inspection they updated the home's policy to reflect amendments to Ontario Regulation 79/10 and implemented air temperature check documented record.

Observations late in the inspection in the same areas showed temperature of 23 degrees Celsius.

Sources: observations of the home and staff interviews. [s. 21. (3)]

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 air temperatures of the home are measured and documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care as set out in the plan of care was documented.

The home submitted a Critical Incident System (CIS) report on a certain date related to a specific resident's fall. CIS indicated that at the time of the fall a specific fall intervention was noted to not be implemented.

A clinical record review of the resident's plan of care showed a specific falls prevention intervention.

A review of the resident's task care record showed no documented evidence that the intervention was provided on the date of the fall.

In an interview Administrator/DOC said there was no documented evidence the specific falls prevention intervention was applied on the date of the fall as this intervention was not on the task care record. They said this intervention should be documented as a provision of care set out in the plan of care. The task care record was updated to show documentation of the provisions of care set out in the plan of care.

Sources: Resident's clinical record and staff interviews. [s. 6. (9) 1.]

Issued on this 10th day of June, 2021

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

Original report signed by the inspector.