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: November 30, 2023
Inspection Number: 2023-1609-0002
Inspection Type: Critical Incident
Licensee: County of Oxford
Long Term Care Home and City: Woodingford Lodge - Ingersoll, Ingersoll

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.12.11 10:56:33 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-29, 2023

The following intake(s) were inspected:

- Intake: #00095500 - CIS: M614-000007-23: Related to Falls Prevention and Management

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:

The resident's plan of care identified an intervention that was not in place during an observation of the resident.

Staff acknowledged that the intervention should have been in place.

With the intervention not in place as required, there was risk that staff would not have been aware if the resident had fallen.

Sources: Observations of the resident, resident's plan of care and interviews with staff.

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WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that the home's falls prevention and management program was followed, specifically where staff were required to complete Head Injury Routine (HIR) monitoring.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the requirements outlined in the Post Fall Assessment for Injury Follow-up related to HIR.

Rationale and Summary:

Staff confirmed that a resident had a fall and HIR monitoring was not initiated.

The homes Administrator acknowledged that according to the homes Post Fall Assessment, HIR monitoring should have been initiated.

There was risk that if the resident had signs and symptoms of a head injury post fall, that they would have gone unnoticed.

Sources: Resident's Post Fall Assessment, progress notes, interviews with staff and the Administrator.

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