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: September 11, 2023
Inspection Number: 2023-1627-0003
Inspection Type: Complaint Critical Incident
Licensee: County of Oxford
Long Term Care Home and City: Woodingford Lodge - Woodstock, Woodstock

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Julie Lampman Digitally signed by Julie Lampman Date: 2023.09.11 09:47:47 -04'00'

Additional Inspector(s) Julie Lampman (522)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28, 29, 30, 31, 2023 and September 5, 6, 2023.
The inspection occurred offsite on the following date(s): September 6, 2023.

The following intake(s) were inspected:

- Intake #00089398/Critical Incident (CI) related to an injury of unknown cause;
- Intake #00089684/CI related to falls prevention and management;
- Intake #00093676/Complaint related resident care;
- Intake: #00093741/CI related to a complaint to the home related to resident care;

The following intake(s) were completed in this inspection:

- Intake #00095497 related to falls prevention and management.
- Intake #00095631 related to falls prevention and management.

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

Infection Prevention and Control

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 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident had a change in condition.

Rationale and Summary
A resident had a change in condition and a specific intervention was put in place. The resident's plan of care had not revised to include the intervention until two days after the intervention should have been in place.

A registered staff member stated they had been told by the resident they were to use the intervention, which was in the resident's room, but there was no order for the use of the intervention. The registered staff member stated the following day, the Nurse Practitioner (NP) had documented the resident was to use the intervention but did not write an order for the use of the intervention.

The NP stated they had documented in the resident's progress notes that the resident was to use the intervention. The NP stated they did not write an order for the use of the intervention as they had thought it would have been part of the resident's orders from another practitioner. The NP stated staff did not contact them to ask them for an order for the use of the intervention. The NP stated registered staff should have called them for a verbal order as the resident should have been using the intervention.

Sources:
Review of the resident's clinical record, and interviews with a registered staff member, the NP and other staff. [522]

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 that the care set out in a resident's plan of care was provided as specified in the plan of care.

Rationale and Summary
The home had submitted a Critical Incident (CI) report related to a complaint from the resident's family regarding how staff responded to a resident's change in condition.

The resident had specific direction on their clinical record if they were to have a change in condition. A registered staff member stated the resident had a change in condition and they had not followed the resident's direction regarding their care.

The Manager of Resident Services (MRS) stated staff should have followed the residents specific direction regarding their care.

Sources:
Review of a CI report, the resident's clinical records, a specific home policy, and interviews with a registered staff member, the MRS and other staff. [522]

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument.

Rationale and Summary
A resident had a fall and was experiencing pain and received as needed pain medication, which at times was ineffective.

It was noted that the resident had sustained injuries, their pain had escalated, and their pain medication was increased. A comprehensive pain assessment had not been completed on the resident after their fall, or after it was determined that the resident had sustained injuries.

Registered Practical Nurse (RPN) #107 acknowledged that the resident did not have a comprehensive pain assessment completed when they fell and were having pain.

Sources:
Review of the resident's clinical record, the home's "Pain Assessment and Management" policy #6.513 with a revision date of January 2023, and interviews with RPN #107 and other staff. [522]