



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2015	2015_418615_0004	005966-15	Complaint

Licensee/Titulaire de permis

SPRUCE LODGE HOME FOR THE AGED
643 West Gore Street STRATFORD ON N5A 1L4

Long-Term Care Home/Foyer de soins de longue durée

SPRUCE LODGE HOME FOR THE AGED
643 WEST GORE STREET STRATFORD ON N5A 1L4

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April, 21, 23 and 30, 2015

The inspection was conducted with Inspector #213.

The complaint was related to level of care.

During the course of the inspection, the inspector(s) spoke with the Director Resident Services, the Clinical Resource Nurse, a Registered Nurse, a Registered Practical Nurse and a Personal Support Worker.

The inspectors also made observations, reviewed health records, policies and other relevant documentation.

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy**

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :



1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Record review of progress notes revealed that a Resident had a fall.

Record review of a Resident care plan revealed that two staff were needed to provide assistance and transfers with a piece of equipment.

Record review of health records for Resident revealed no evidence of an assessment of the Resident's needs for the use of a piece of equipment.

Staff interview with the Clinical Resource Nurse and Registered staff confirmed that there was no physiotherapist assessment done for the use of the equipment. [s. 6. (2)]

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 with the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights



Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that every resident has the right to, participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters.

Record review of progress note revealed that a Resident was sent to the hospital for an assessment.

Record review of progress note revealed no evidence of obtaining consent from the Resident's Power Of Attorney (POA), to transfer the Resident to the hospital.

Staff interview with the Director Resident Services confirmed the absence of documentation to support that the consent was obtained from the POA to send the Resident to the hospital.

Interview with the POA revealed that a telephone call was received at a specific date to inform that the Resident was sent to the hospital. POA confirmed that no consent was given at that time.

The home did not allow the POA to participate in the decision to transfer Resident #1 to the hospital. [s. 3.(1) 11. iii.] [s. 3. (1) 11. iii.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :



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1. The licensee has failed to ensure that the Director is informed of an injury in respect of which a person is taken to the hospital, no later than one business day after the occurrence of the incident.

Record review of progress notes revealed that on a specific date, a Resident had a fall, was transferred to the hospital and returned to the home with a change in condition.

The Registered staff confirmed this was a significant change in the Resident's status.

The Clinical Resource Nurse and the Director Resident Care confirmed the Director was not notified of this incident as required under the legislation.

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.