Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 21, 24, 2016	2016_254610_0032	030051-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
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

NATALIE MORONEY (610), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 13, 14, 17, 18, 19, 2016

Critical Incident # M575000004-16, log # 019301-16 was completed related to falls and was completed concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, one Director of Care, one Clinical Resource Nurse, one Life Enrichment Coordinator, one Registered Nurse, one Environmental Service Manager, one Housekeeper, three Registered Practical Nurses, seven Personal Support Workers, family members, and residents.

During the inspection the inspector(s) reviewed health care records, conducted interviews, completed observation of resident care, and reviewed relevant documentation and policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, or registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Resident # 023 had a diagnosis that affected decision making regarding safety.

A review of the home's Core Programs Policy for Restraint/PASD revised March 2016 indicated:

"A physicians order will be obtained once the consent is obtained.....the physicians order should state the type of device to be used and the purpose of the device. Registered staff will reassess the resident every eight hours on the electronic record".

On October 20, 2016, a review of the electronic record showed that the resident did not have a current physician order for an identified intervention.

Registered Nurse Team Leader (RNTL) #114 said that when they obtained the intervention they should have obtained the order from the physician.

The Clinical Resource Nurse #101 on October 20, 2016, said that they should have had a current order for the use of the intervention and acknowledged they had not. [s. 31. (2) 4.]

Issued on this 21st day of October, 2016

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

Original report signed by the inspector.