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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jul 6, 2020	2020_725522_0002	005106-20, 007277-20	Critical Incident System

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

JULIE LAMPMAN (522)

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 19, 22, 23, 24, 25 and 30, 2020.

The following intakes were inspected during this inspection:

Critical Incident System (CIS) report #M575-000011-20/Log #005106-20 related to falls prevention.
CIS report #M575-000012-20/Log #007277-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Assistant Director of Resident Care, the Life Enrichment Manager, the Therapy Coordinator, Registered Nurses, a Registered Practical Nurse, and Personal Support Workers.

The inspector also reviewed, resident clinical records, risk management reports, and policies and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 30 (1) 1 states, “Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.”

Ontario Regulation 79/10 s. 48 (1) states, “Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.”

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the fall of resident #002.

Review of the CIS report noted that resident #002 had an unwitnessed fall and a head injury routine was initiated.

Review of the home’s “Head Injury” policy #RCM 2-1-1 with a revision date of June 20, 2017, noted the following:

“When a resident has fallen (witnessed or unwitnessed) the R.A. staff will immediately notify the registered staff.
“Registered Staff: If the resident is verbally able to communicate having hit their head, or if the resident is cognitively impaired, and it is not able to be reliably determined, the Registered Staff will initiate a Head Injury Routine (HIR).”
“Head Injury Routine:
Take all vitals, assess pupil reaction and size, orientation and limb movement. Observe and record vital signs as follows on Head Injury Routine Form.
1. Initial Exam
2. Hourly x 4
3. If vital signs stable continue with step 5 or 6
4. If vital signs not stable continue every 4 hours for 20 hours
5. Then every shift times 24 hours, if improvement noted
6. OR more frequently as determined by medical condition or physician order
7. All residents with actual or suspected head injury must be wakened to complete Neurological Vital Signs and chart on the HIR Form.”

Review of resident #002’s Spruce Lodge Head Injury Routine Form noted resident #002's HIR was initiated on a specific date and time. The next HIR was completed three hours and 32 minutes after the initial assessment.

HIR assessments were then completed twice at hourly intervals, then two more assessments were completed at times outside the intervals indicated in the Head Injury policy.

During an interview, Registered Nurse (RN) #107 stated that a HIR should be completed for an unwitnessed fall. RN #107 stated that an initial HIR assessment would be completed, then completed hourly for four hours and then every shift for 24 hours after that.

RN #107 stated that they had completed the initial HIR assessment for resident #002 after their fall and then the remainder of the assessments would have been completed by the registered practical nurse on the unit. RN #107 stated the HIR for resident #002 should have been completed hourly for four hours after the initial assessment.

During an interview, Director of Resident Care (DRC) #100 stated the HIR assessment for resident #002 should have been completed hourly for four hours after the initial HIR

assessment. DRC #100 stated that the time interval between the last two HIR assessments was too long.

The licensee has failed to ensure that the home's "Head Injury" policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 the home's Falls Program policy is complied with, to be implemented voluntarily.

WN #2: 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the fall of resident #001.

Review of the CIS report noted a significant change in resident #001's condition two days after the fall.

Review of resident #001's electronic progress notes on Point Click Care (PCC) noted resident #001 had a significant change in condition two days after their fall.

During an interview, Assistance Director of Resident Care #108 stated they were still learning reporting requirements and had submitted the CIS report two days after noting the resident had a significant change in condition.

During an interview, Director of Resident Care #100 stated the CIS report for the fall of resident #001 should have been submitted when it was determine the resident had a significant change in condition.

The licensee has failed to ensure that the Director was informed of the fall of resident #001 for which resident #001 had a significant change in condition, no later than one business day after the occurrence of the incident [s. 107. (3) 4.]

Issued on this 7th day of July, 2020

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

Original report signed by the inspector.