Ontario

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

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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
Jul 23, 2015	2015_260521_0037	010394-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPRUCEDALE CARE CENTRE INC
96 KITTRIDGE AVENUE EAST STRATHROY ON N7G 2A8

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

SPRUCEDALE CARE CENTRE
96 KITTRIDGE AVENUE EAST STRATHROY ON N7G 2A8

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

REBECCA DEWITTE (521), DONNA TIERNEY (569), SALLY ASHBY (520)

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): June 15, 16, 17, 18, 19, 23, 24 and 25, 2015.

During the course of the inspection, the inspector(s) spoke with the Licensee, Executive Director, Director of Care, Clinical Care Coordinator, Director of Environmental Services, one Registered Nurse (RN), seven Registered Practical Nurses (RPN), one Physiotherapist, one Recreation Manager, four Personal Support Workers (PSW), one Dietary Aide and one contracted Hairdresser, 40+ Residents and four Family Members.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident staff interactions, recreational activities, dining service, medication administration, medication storage areas, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, as well as the home's staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

An interview with a family member revealed they had not been given the opportunity to participate fully in the development of the resident's recent plan of care.

A review of notes revealed the family member had questioned the plan. No further documentation was present to verify the family member had been involved in the development of the plan of care.

An interview with the Director of Care confirmed it was the home's expectation that the family member should have been given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A record review revealed a resident was to receive specific interventions.

Observations revealed documentation was missing for multiple days.

An interview with the Clinical Care Coordinator confirmed that the resident had received

these specific interventions but the documentation had not been completed. The Clinical Care Coordinator confirmed that it was the homes expectation that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.]

3. Observations revealed a resident had a treatment.
Later observations revealed the resident had two treatments.

An interview with the Registered Practical Nurse revealed the treatments would be completed and documented in the Treatment Administration Record.

A record review of the Treatment Administration Record revealed no documentation of when the treatments were completed or when they were due to be completed.

An interview with the Clinical Care Coordinator confirmed it was the home's expectation that the treatment would be documented in the Treatment Administration Record. [s. 6. (9) 1.]

4. A record review of a resident's plan of care revealed the resident was to be monitored frequently and that care was to be documented.

Observations revealed missing documentation for multiple shifts in a row.

An interview the Director of Care verified the missing documentation and confirmed it was the home's expectation that the provision of the care set out in the plan of care was documented. [s. 6. (9) 1.]

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 that the resident's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and the provision of the care set out in the plan of care was documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all resident's beds have a headboard and a footboard.

Observations revealed some beds did not have a footboard.

An interview with the Environmental Manager confirmed the beds were without the footboards and it was the home's expectation that all of the beds have footboards. [s. 12. (2) (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 that all residents' beds have a headboard and a footboard, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During the initial tour of the home and resident observations, the following maintenance concerns were identified:

In a specific home area.
The door to the activity room was observed with scratches, marks and chunks of wood missing.
The door to the dining room was observed with scratches, marks and chunks of wood missing.
The door to a Resident's washroom was observed with scratches and marks.
The wall had damage.
The pillar had damage.
The veneer had damage to lower cupboards in the dining room,
A room had extensive damage to sink counter with product missing along the edge.

In another home area.
The pillars had damage in the hallways.
The base of fireplace in the T.V. room was observed to be extensively scratched.

In the main area.
The door to the Emergency Exit was observed with scratches and marks.
The wall had damage in the chapel.
The patch was not painted on the wall area in the chapel.
There was wall damage in the coat rack area.
There were two holes in the wall behind bench under the mural.
There was a hole in floor (covered with cardboard) under the bench near the fountain.

In another home area.
A door to a bathroom was observed with scratches and marks.
The walls had damage.
The door to a resident's washroom was observed with scratches and marks.

A tour with the Director of Environmental Service verified and confirmed the identified maintenance concerns. [s. 15. (2) (c)]

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 that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times.

Observations revealed the call bell system light was not working. A review of the activated call system record revealed the call system did not record as activated on the pager or the computer system.

Further observations revealed some of the call bell system lights were also not working.

This was confirmed by the Environmental Manager. [s. 17. (1) (a)]

2. Observations revealed a resident lying in bed. The call bell attached to the wall remote station was not within reach of the resident. The resident did not have a portable tracker alarm on their person or in their bed.
This observation was confirmed by a Personal Support Worker (PSW).

Another resident was lying in bed. The call bell attached to the wall remote station was also not within reach of the resident. The resident did not have a portable tracker alarm on their person or in their bed. This observation was also confirmed by a PSW.

A resident was observed in a reclined chair in the TV lounge. A portable tracker alarm could not be found within reach of the resident. This observation was confirmed by a PSW.

An interview with the Director of Care confirmed that it was the home’s expectation that all residents should have a resident-staff communication and response system accessible to them at all times. [s. 17. (1) (a)]

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 that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all time, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

A resident was noted to have untrimmed and unclean fingernails.

A review of the resident care plan stated nails were to be manicured on bathing day.

A review of the bath schedule revealed the resident would be bathed twice a week.

A interview with the Director of Care verified that the resident had received a bath as per the bathing schedule.

The resident was observed with untrimmed (6mm) and unclean fingernails.

The Personal Support Worker verified the unclean and untrimmed fingernails and further confirmed that the resident had not received fingernail care during the scheduled bath. [s. 35. (2)]

2. Observations of resident revealed the resident had thick brown grime under the tips of the resident's fingernails.

Later observations revealed the resident continued to have thick brown grime under the tips of the nails.

An interview with the resident's Power of Attorney revealed they often visited and found the resident in need of nail care.

The record revealed the resident had not received a bath as per the schedule.

The Director of Care confirmed the resident had not received the scheduled bath and it was the home's expectation that nail care be provided during the resident's bath to ensure residents receive nail care. [s. 35. (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 to ensure that the resident receive fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

Observations revealed Windex with Amonia D was in a bathroom. This was verified by the Registered Practical Nurse who confirmed it was the homes expectation that all hazardous substances were kept inaccessible to residents at all times. [s. 91.]

2. Observations revealed the spa room door was propped open with no staff in attendance or in the immediate area. The following hazardous substances were noted accessible:

a)Heavy Duty Alkaline Bathroom Cleaner & Disinfectant
b)Peroxide Multi-Surface Cleaner

A staff member confirmed the spa door was propped open and verified the hazardous substances were accessible to residents. [s. 91.]

3. During the initial tour of the home, the hair salon was observed open and unattended with a resident in the salon sitting under an operating hairdryer.

The closet door inside the salon was open and a variety of hair products and chemicals were noted to be inside the closet including a jug of barbicide, hair colouring solution, aerosol hairspray, peroxide, and a jug of bleach.

The hair stylist returned and confirmed the closet which housed the chemicals had been left open in her absence and should have been closed and secured.

An interview with the Director of Care confirmed it was the home's expectation that all hazardous substances were to be kept inaccessible to residents at all times. [s. 91.]

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 that all hazardous substances are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A staff member gave medication to a resident. The resident took the medication to the dining table and began the meal.

Throughout the observed medication pass the resident did not take the medications.

A record review revealed the physician order stating "ensure resident takes meds". An interview with the Registered Practical Nurse confirmed they had not ensured the resident had taken the given medications.

An interview with the Director of Care confirmed it was the home's expectation that the nurse would administer the medications as prescribed. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that was secure and locked.

Observations revealed a specific treatment for a resident was on the bedside table. A record review revealed the resident did not have an order to self administer the specific treatment.

A staff member verified the specific treatment was on the bedside table. The Clinical Care Coordinator confirmed it was the homes expectation that drugs were stored in an area or medication cart that is secure and locked. [s. 129. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record was kept up to date at all times.

A record review of a resident's Minimum Data Set (MDS) revealed the resident was fully incontinent.
A record review of the resident's care plan for urinary incontinence stated "resident will remain continent of bladder" and "to cooperate in establishing a routine for urine elimination".

An interview with the Clinical Care Coordinator confirmed that the care plan was not up to date and it was the home's expectation that the resident's records should be kept up to date at all times. [s. 231. (b)]

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Issued on this 1st day of September, 2015

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

Original report signed by the inspector.