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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2019	2019_729615_0001	000821-17, 021535-17, 027252-17, 027550-17, 027821-17, 002305-18, 003219-18, 016596-18, 017039-18, 018321-18	Critical Incident System

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

HELENE DESABRAIS (615), CHRISTINA LEGOUFFE (730)

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): January 2, 3 and 4, 2019.

The following Critical Incident (CI) Report were inspected during this inspection:

CI #2946-000010-17/Log #021535-17 related to medication;
CI #2946-000016-17/Log #027252-17 related to prevention of abuse and neglect;

CI #2946-000002-17/Log #000821-17 related to prevention of falls;
CI #2946-000017-17/Log #027550-17 related to prevention of falls;
CI #2946-000018-17/Log #027821-17 related to prevention of falls;
CI #2946-000001-18/Log #002305-18 related to prevention of falls;
CI #2946-000005-18/Log #016596-18 related to prevention of falls;
CI #2946-000006-18/Log #017039-18 related to prevention of falls;
CI #2946-000002-18/Log #003219-18 related to infection prevention and control;
CI #2946-000007-18/Log #018321-18 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with The Assistant Administrator, the Director of Care, a Registered Nurse, two Registered Practical Nurses, a Physiotherapist and two Personal Support Workers.

During the course of the inspection, the inspector(s) also observed resident/staff interactions, reviewed relevant resident clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that was setting out clear directions to staff and others who provided direct care to the resident.

Two Critical Incident System (CIS) reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home on a specific date, which identified that two residents had sustained a fall that resulted in injuries.

A review of the care plan in Point Click Care (PCC) for the two residents stated in part to ensure a specific device was in place.

During an observation of the two residents' room on a specific date, Inspector #730 observed a signage in the residents' washroom which circled specific falls prevention devices as not being in use and one of the specific device was not observed in the resident's room.

A review of the home's policy #NS.20.02 "Falls and Fall Prevention Program" dated June 2018, stated in part " The program focuses on reducing the incidence of residents' falls and mitigating risks of falls through a resident focused, team approach which ensures that a resident's environment and social, physical, cognitive and emotional strengths are supported. The program ensures team training, communication and effective care planning" and "Registered Nursing Staff: Review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team".

During an interview with a PSW when asked how they would know what interventions were in place for falls prevention for a resident, they stated that they would look in Point of Care (POC), ask a nurse, or look at the signage in the resident's bathroom.

During interviews, two RPNs stated that the residents had the specific device in their care plan as falls prevention measures. The RPNs showed inspector #730 the signage in the residents' room and stated that the signage indicated that the resident did not use the specific devices. When asked if the specific device was being used for one resident,one RPN stated that they did not know. When asked if they would consider the care plan for the resident to be clear, the RPN stated "no". The other RPN stated that it did not include the use of a specific device for the other resident and just updated the care plan.

During an interview, the Physiotherapist stated that both residents required the specific device.

During an interview, the DOC stated that they would expect the residents' care plans gave clear directions to staff.

The licensee has failed to ensure that the written plan of care for the residents was setting out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.