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
May 13, 2015	2015_264609_0032	007619-15	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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 12, 2015

This inspection was conducted as a result of a complaint submitted to the Ministry related to baths.

During the course of the inspection, the inspector(s) spoke with the Director, the Nurse Manager, one Registered Nurse (RN), one Scheduler, one Personal Support Worker (PSW) three Residents and one Resident Family Member.

The inspector(s) also reviewed staff attendance logs, clinical records, plans of care and Resident Council Minutes.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as

determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of the Resident Council Minutes for April 24, 2015, revealed missed baths were a concern identified by the residents. In the meeting minutes residents complained that they were being bathed once a week.

A review of the Weekly Missed Bath List for one month revealed a total of 163 bathing sessions were missed in a facility of 126 beds.

An interview with the Staff Scheduler revealed that in one month 12 shifts specifically allotted for bathing were vacant.

A review of the Weekly Missed Bath List for a seven day period revealed 21 residents were identified has having a missed bath. Of those identified 17 or 80 percent did not receive a bath before the next regularly scheduled time slot.

The Director and the Nurse Manager confirmed that it is the home's expectation that all residents are bathed at least two times a week and in the case of the 163 missed baths in the specified month that this did not occur. [s. 33. (1)]

2. The licensee has failed to ensure that a resident is bathed, at a minimum, twice a week.

An interview revealed that on a specified day an identified resident did not receive a bath as specified in the plan of care.

A review of the clinical record revealed that the missed bath was not made up and that the identified resident waited until the next scheduled bath day. [s. 33. (1)]

3. The licensee has failed to ensure that a resident is bathed by the method of his or her choice.

An interview with an identified resident and a member of the resident's family revealed that on a specified day the bath was missed. The resident confirmed that the preferred method was not offered as specified in the plan of care. The resident's family member revealed that staff told the resident that there was only time for an alternative method of bathing as there was no staff available to provide a bath. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 13th day of May, 2015

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

Original report signed by the inspector.