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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Jan 25, 2016	2016_229213_0004	000119-16 000803-16	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

RHONDA KUKOLY (213)

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 14 & 15, 2016

This critical incident inspection was completed related to three critical incidents:
Log #000119-16, CI #M575-000001-16 related to an allegation of abuse
Log #000803-16, CI's #M575-000002-16 and M575-000013-15 related to resident to resident abuse.
This inspection was completed while in the home also completing three complaint inspections (log #033136-15, #035362-15 and #035554-15).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, three Registered Practical Nurses, the Life Enrichment Manager, the Support Services Manager, four Resident Assistants, one family member and three residents.

The Inspector also made observations and reviewed health records, policies and procedures, internal investigation records, education records and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

Record review of progress notes for resident #005 and #004 and the critical incident report, revealed that on an identified date, resident #004 was physically aggressive toward, causing physical injury to resident #005.

Record review of progress notes for resident #004 and the critical incident report, revealed that resident #004 had a physical altercation with resident #006 on an identified date, causing physical harm to resident #006. On an identified date, resident #004 was physically aggressive causing physical injury to resident #005.

Staff interview with Registered Practical Nurses #108, #109 and #117 on January 15, 2016, revealed resident #004's behaviour was unpredictable with a potential for verbal and physical aggression. Staff interview with Resident Assistant #118 on January 15, 2016, revealed resident #004 showed threats of aggression toward other residents.

Record review of the health record for resident #004 revealed a Daily Observation Sheet (DOS) was started on an identified date, to monitor and document this resident's behaviours. Behavioural observations were documented on three dates. A Cohen Mansfield Agitation Inventory was completed on an identified date, and revealed many responsive behavious being exhibited.

A review of the Behavioural Supports Ontario (BSO) binder on the unit revealed a referral to the BSO program was sent on an identified date for resident #004 and #006 related to a physical altercation. Residents #004 and #006 were on the BSO resident list; however, no assessments, triggers, interventions or strategies were found related to either of these residents.

The Director of Care #102 confirmed in an interview on January 15, 2016, that the home did not appropriately assess resident #004 related to responsive behaviours and/or behavioural triggers, and did not protect resident #005 from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

Record review of progress notes for resident #005 and #004 and the critical incident report, revealed that on an identified date, resident #004 was physically aggressive toward, causing physical injury to resident #005.

Staff interview with Registered Practical Nurses #108, #109 and #117 on January 15, 2016, revealed resident #004's behaviour was unpredictable with a potential for verbal and physical aggression. Staff interview with Resident Assistant #118 on January 15, 2016, revealed resident #004 showed threats of aggression toward other residents.

Record review of the health record for resident #004 revealed a Daily Observation Sheet (DOS) was started on an identified date, to monitor and document this resident’s behaviours. Behavioural observations were documented on three dates. A Cohen Mansfield Agitation Inventory was completed on an identified date, and revealed many responsive behavious being exhibited.

A review of the Behavioural Supports Ontario (BSO) binder on the unit revealed a referral to the BSO program was sent on an identified date for resident #004 and #006 related to a physical altercation. Residents #004 and #006 were on the BSO resident list; however, no assessments, triggers, interventions or strategies were found related to either of these residents.

The Director of Care #102 confirmed in an interview on January 15, 2016, that steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions. [s. 54.]

Issued on this 9th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2016_229213_0004
Log No. / Registre no:	000119-16 000803-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 25, 2016
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
LTC Home / Foyer de SLD :	SPRUCE LODGE HOME FOR THE AGED 643 WEST GORE STREET, STRATFORD, ON, N5A-1L4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER BOLLAND

To The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The home must achieve compliance to ensure that residents are not abused by anyone in the home.

The licensee will take steps to minimize the risk of altercations and potentially harmful interactions between resident #004 and other residents including:
a) Identify and document factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
b) Identify, document and implement interventions.

Further to this, the licensee will take steps to minimize the risk of altercations and harmful interactions between any and all residents when applicable including:
a) Identify and document factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
b) Identify, document and implement interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

Record review of progress notes for resident #005 and #004 and the critical incident report, revealed that on an identified date, resident #004 was physically aggressive toward, causing physical injury to resident #005.

Record review of progress notes for resident #004 and the critical incident report, revealed that resident #004 had a physical altercation with resident #006 on an identified date, causing physical harm to resident #006. On an identified date, resident #004 was physically aggressive causing physical injury to resident #005.

Staff interview with Registered Practical Nurses #108, #109 and #117 on January 15, 2016, revealed resident #004's behaviour was unpredictable with a potential for verbal and physical aggression. Staff interview with Resident Assistant #118 on January 15, 2016, revealed resident #004 showed threats of aggression toward other residents.

Record review of the health record for resident #004 revealed a Daily Observation Sheet (DOS) was started on an identified date, to monitor and document this resident's behaviours. Behavioural observations were documented on three dates. A Cohen Mansfield Agitation Inventory was completed on an identified date, and revealed many responsive behavious being exhibited.

A review of the Behavioural Supports Ontario (BSO) binder on the unit revealed a referral to the BSO program was sent on an identified date for resident #004 and #006 related to a physical altercation. Residents #004 and #006 were on the BSO resident list; however, no assessments, triggers, interventions or strategies were found related to either of these residents.

The Director of Care #102 confirmed in an interview on January 15, 2016, that the home did not appropriately assess resident #004 related to responsive behaviours and/or behavioural triggers, and did not protect resident #005 from abuse. (213)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

Service Area Office /
Bureau régional de services : London Service Area Office