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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2017	2017_678680_0012	017806-17	Resident Quality Inspection

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

TRACY RICHARDSON (680), ADAM CANN (634), ALI NASSER (523), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 14, 15, 16, 17, 18, 21, 22, 23, 24, 2017.

The following intakes were inspected during the Resident Quality Inspection:
Complaint Intakes Inspected:
Log #011518-16, IL #44213-LO, related to allegations of neglect
Log #026572-16, IL #46359-LO, related to bathing

Log #013233-17, IL #51533-LO, related to bathing
Log #011675-17, IL # 51304-LO, related to menu planning and staff concerns
Log #011740-16, IL #44270-LO, related to allegations of damage to personal property
Log #017159-16, IL #44978-LO, related to allegations of abuse
Log #005063-17, IL #49689-LO, IL #49740, related to allegations of staff to resident abuse
Log #003975-17, IL #49435-LO, related to allegations of abuse
Log #006940-17, IL #50161- LO, related to staffing, bathing, and continence care
Log #004519-17, IL #49575-LO, related to allegations of abuse
Log #029512-16, IL#47053-LO, IL #47136, IL #47164-LO, related to allegations of neglect
Log #012672-17, IL #51457-LO, related to allegations of abuse
Critical Incident Intakes Inspected concurrently during the Resident Quality Inspection:
Log #005422-17, Critical Incident #M575-000004-17, related to falls
Log #000200-17, Critical Incident #M575-000001-17, related to falls
Log #007946-17, Critical Incident #M575-000005-17, related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Resident Assessment Instrument (RAI) Coordinator, the Clinical Resource Nurse, the Environmental Services Manager, Dietary Aides, Resident Assistants, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Human Resource Coordinator, Residents' Council Representative, Life Enrichment Manager, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care, and the general maintenance and cleanliness of the home. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care Information and inspection reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's attending physician and the resident's substitute decision maker (SDM).

Review of the home's Medication Incident/Near Miss reports and corresponding clinical records for a specified time frame were reviewed.

A) On a specified date, a medication incident occurred involving a specific resident. The form did not indicate that the physician, or substitute decision maker (SDM), had been notified. There was no documentation on the Medication Incident/Near Miss report in the residents progress notes indicating that the the resident's physician and SDM were notified of the incident.

B) On a specified date, a medication incident occurred involving another specified resident. There was no documentation on the Medication Incident/Near Miss report or in in the residents progress notes indicating that the the resident's physician and SDM were notified of the incident.

Interview was completed with a registered staff member, who was named on the medication incident form as the nurse involved in the medication incident. The specified nurse said that if a resident was effected by the medication error, the staff would only then notify the resident or Power of Attorney (POA)/ Substitute Decision-Maker (SDM), and the resident's physician.

A registered staff nurse said that if the resident was involved in a medication incident, but did not suffer any harm, the resident or POA/SDM, and the attending physician would not be notified. The pharmacy received a fax of every medication incident form. The registered staff member said that if the resident, POA or SDM, or the resident's attending physician were contacted, they would expect to see it charted on the medication incident form, or in the resident's progress notes.

Interview was completed with a Registered Nurse. The RN stated that the home did not always notify the resident or POA/SDM, and the attending physician. The RN stated that the resident or POA/SDM, or attending physician would not be notified unless there was actual harm to the resident regardless if the medication incident involved the resident or not.

Interview was completed with Clinical Resource Nurse (CRN). The CRN was asked to look for documented evidence of the immediate actions taken to assess, and maintain the two specified residents health. The CRN could not find any documented evidence to show that actions were taken to assess and maintain the resident's health.

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and a written record was kept.

Review of the home's Medication Incident/Near Miss reports and corresponding clinical records for a specified time frame were reviewed.

On a specified date, a medication incident occurred involving a specific resident. The report was missing documentation regarding root cause and contributing events that led to the medication errors.

In an interview a registered staff member stated that they were notified that they were involved in a medication incident on a specific date. The registered staff member said that one of the Team Leads explained the error to them on their next shift. The registered staff member stated that the Director of Care did not follow up with them to review what had happened. The registered staff member stated that "nothing changed after this incident happened, it could totally happen again".

Interview was completed with Clinical Resource Nurse (CRN) and a Registered Nurse (RN) on a specified date. The RN stated that it was typically the responsibility of the Director of Care to complete the review and analysis section of medication incidents. The RN said that the Director of Care would fill out the back of the Medication Incident/ Near Miss report to complete the review, analysis and corrective action. The RN stated that the previous Director of Care would write on the back of "some of the medication incident forms but was not sure if they completed a review of all medication incidents."

Interview was completed with the former Director of Resident Care (FDRC) at the time of the above mentioned medication incidents. The FDRC stated that the responsibility for completing a full review and analysis of each medication incident was the responsibility of the Director of Resident Care (DRC). The FDRC said that they would base their decision to complete a review and analysis based on the effect on the resident and not if the resident was involved in the incident. The FDRC said that they would document the review and analysis on the Medication Incident/Near Miss report. The FDRC said that if the review and analysis was not completed on the back of the form then the review and analysis had not been completed.

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and a written record was kept.

3. The licensee has failed to ensure that a written record was kept of the quarterly review that was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Record review was completed of the minutes from the Professional Services Committee (PSC) Meeting for a specific date. The topic and points of discussion included a summary of Medication Incidents for the specified time period. The summary did not show any documentation of the strategies to be implemented to reduce and prevent medication incidents.

In an interview, Clinical Resource Nurse (CRN) stated that the quarterly review of medications was completed at the PSC meeting. The CRN said that the medication incidents were reviewed at the meetings in order to reduce and prevent medication incidents. The CRN was asked if changes were identified during the last PSC meeting and they stated that there were but could not recall exactly what they were. The CRN could not provide documented evidence showing a quarterly review occurred in order to reduce and prevent medications incidents.

The licensee has failed to ensure that a written record that was kept of the quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread. The home has a history of previous unrelated noncompliance. [s. 135. (3)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) A review of an Infoline complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) for a specified resident identified that residents were denied tray service and denied eating in their rooms if residents were capable of going to the dining room for their meals.

In an interview the specified resident expressed concern regarding meal tray service not being provided to them in their room if they refused to come to the dining room for a meal. The resident said that sometimes they did not want to go for meals in the dining

room related to a condition they had.

In an interview a specific Resident Assistant (RA) stated that bringing food to the specified residents room had recently been inconsistent and "that staff are not supposed to do tray service unless a resident is ill or on isolation." A registered staff member said that staff do not give the resident "a meal in their room because of a specific risk, however, staff provide them with fluids. In an interview with the Director of Resident Care (DRC) they agreed that tray service may be available for residents when requested and explained that the criteria for tray service was outlined in the home's policy.

B) Review of an Infoline complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) identified that a specified resident had requested not to have specified staff care for them.

In an interview with the specified resident, they shared that the treatment from staff was still ongoing.

A review of the progress notes for the specified resident stated that at the beginning of the shift, the resident was refusing care from specified staff. They informed the resident that certain staff were unavailable. The progress note on that date stated that the specific resident wished to speak with registered nurse (RN) to tell the nurse that staff refused to assist with a certain activity of daily living, the resident had stated that staff told them they did not require that assistance. Further in the note it stated that the specified resident insisted that they required the specified activity of daily living. The documentation showed that assistance for the specified activity of daily living was not completed.

In an interview an Resident Assistant (RA) stated the specific resident did not allow certain staff to assist with the specified activity of daily living. The RA shared that when there are certain staff on a certain shift, they need to wait for the specified team member from another area to come and assist them. The RA stated that at times the resident may wait approximately twenty minutes for assistance. The RA shared that the requested assistance for a specified activity of living was not done on that shift.

The Registered Nurse (RN) , stated that the specified resident complained staff do not assist with them the specific activity of daily living.

In an interview, Director of Resident Care (DRC) stated that a staff member should assist the resident with the specified activity of daily living when asked by the resident, and if

there were ongoing issues that the information be documented and reviewed later.

The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

2. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 11. iv. to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care.

A) During Stage 1 of the Resident Quality Inspection (RQI), resident Kardexs were observed posted on a bulletin board in the bathrooms of each room. The Kardex was noted to be hung in an area where it could be easily viewed by other residents sharing the bathroom and their visitors. The Kardex had the resident name, date of birth, date of admission and was noted to show continence requirements and behaviours that the resident exhibited, personal information regarding their care needs was detailed on the Kardex.

Observations on a specified date, in a specific residents room, the Kardex showed that the resident had a specific medical condition and that staff were to monitor. The date of admission, date of birth and allergies were noted on the form. The form had specific instructions as to per the care routine for this resident.

Observations on a specified date, in another residents room, the Kardex contained information pertaining to specific care of the resident. Also noted on the Kardex for this specific resident was date of birth, date of admission, and allergies. The form had specific instructions as to per the care routines of this resident, and had personal information regarding their care needs. This specific resident shared a bathroom.

Review of the home's policy titled Care Plan, stated "After initial care plan completion and with any changes made to the care plan; the resident kardex is printed and placed on the resident's care board for reference by any direct care staff."

In an interview the CRN stated that the care plan policy directed them to place the Kardex in the resident's bathroom. The CRN stated that the families were very involved and often would bring suggestions to them to add to the Kardex. The CRN acknowledged

that the medical conditions should not be visible and would change that right away. The CRN stated that the home received consent to share information with other health care personnel and that was the intended use of the Kardex.

Director of Resident Care (DRC) acknowledged that the Kardexes were accessible in the bathrooms of the residents in the home to anyone sharing a bathroom or visitors.

B) On a specified date, a specialized binder was found in an unlocked cupboard in the common lounge area. The cupboard was accessible to residents who were sitting in that area at the time. The binder contained a printed care plan for a specified resident. The care plan listed the residents health conditions as well as their date of birth, date of admission and care requirements.

Clinical Resource Nurse acknowledged that the specified binder was in the cupboard in the common lounge and not locked. The CRN stated that the binder was behind a closed door and not visible, and it was acceptable to be in that area.

In an interview the DOC shared that the binder should not have been in the unlocked cupboard. The DRC acknowledged that personal health information was available on the plan of care. DRC removed the binder from the cupboard at that time.

The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 11. iv. to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was a pattern. This area of non-compliance was previously issued on April 21, 2015, as a written notification under complaint inspection # 2015_418615_0004 [s. 3. (1) 11. iv.]

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 every resident rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. The following rights of residents are fully respected and promoted: that every resident was cared for in a manner consistent with their needs, and every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a bed rail was used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During Stage 1 of the Resident Quality Inspection (RQI), it was noted that there were three beds observed in three rooms , with a large gap between the mattress and the headboard. On several occasions in one of the rooms, the mattress was not in the keeper. During the observations, the bed in the other two rooms had side rails noted in the upright position.

Review of the point click care assessments noted that no bed rail assessments were present for either resident in those two rooms. Review of the resident chart binder did not reveal any bed rail assessments.

In an interview the Clinical Resource Nurse, stated that the there was no formal assessment for when bed rails were used on a resident. That rails were assessed with bed system and due to the fact the bed equipment was deemed safe there would be no risk to the resident in using side rails if they required them. Clinical Resource Nurse stated no further assessments were completed of the rails once the entrapment assessment was completed.

Director of Resident Care (DRC) shared that there was no formal assessment for residents requiring bed rails. The DRC stated that when bed rails were used, a consent was obtained for a Personal Assistance Services Device (PASD), and then the information was placed in the plan of care for staff.

The licensee has failed to ensure that when a bed rail was used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The severity of this non-compliance is minimal harm/risk or potential for actual harm/risk and the scope is isolated. The home has a history of previous unrelated noncompliance. [s. 15. (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 when a bed rail is used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations showed that 12 windows in the Alcove Link hallway were opened 58 centimetres. Cottage A common area window, two other resident rooms windows opened 25 centimetres.

Two inspectors with the DRC observed the windows. DRC acknowledged that the windows opened more than 15 centimetres.

Environmental Services Manager (ESM) observed the windows in Alcove Link and acknowledged that the windows opened more than 15 centimeters. Observations in a specified room , North Dining room, and palliative room showed that those sliding windows had a tilt function, once activated the window would open two by two feet.

ESM acknowledged that the windows opened more than 15 centimetres and said that the windows should not open more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

The severity of this non-compliance is a level 2 with minimal harm/risk or potential for actual harm/risk and the scope is widespread. The home has a history of previous unrelated noncompliance. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents can not be opened more than 15cm, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding a specific resident who had a fall, which resulted in a specific injury.

During observations the specified resident was seen with a specific PASD.

Record review of the Care Plan showed that the specified resident did not contain information regarding the specific PASD.

Review of the Kardex that was posted in the specified residents bathroom did not contain information regarding the specific PASD.

In an interview with a Resident Assistant (RA), stated that as soon as the resident was in their wheelchair they applied the specific PASD. The RA shared that the specific resident was unable to release the specific PASD on their own.

The RA stated that the staff were using the specific PASD for the specific resident for some time. The RA acknowledged that the specific PASD was not in the Kardex.

In an interview with a registered staff member they shared that the specified resident was not capable of taking the specific PASD off.

A Registered Nurse (RN) acknowledged that the specific PASD was not included in the specific residents plan of care. The RN stated that the specific PASD should not have been applied. The RN acknowledged that the resident had the specific PASD on when observed with the inspector. The RN shared that the resident was not capable of removing the specific PASD.

In an Interview with the Director of Resident Care (DRC), they stated that the specific PASD was not to be used on the specified resident and was not in the plan of care for the resident.

The licensee has failed to ensure that the use of a specific PASD being used on a specific resident was in the plan of care, that an order had been obtained for the use of the specific PASD, consent from the power of attorney to use the specific PASD on the resident was obtained, and monitoring requirements were met.

The severity of this non-compliance is a level 2, minimal harm/risk or potential for actual harm/risk and the scope is isolated. The home has a history of previous unrelated noncompliance. [s. 33. (3)]

2. Observations of a specified resident showed they had a specific PASD in place.

Review of Consent for Use of Restraint/Personal Assistance Services Device (PASD) form signed by the physician indicated that this specified PASD was not marked on the form for use.

Record review of the resident's Care Plan did not show any directions for the use of the specific PASD.

Review of the Kardex that was posted in the residents bathroom, did not show any directions for the use of the specific PASD. The CRN added the PASD to the kardex, however there was no mention of the frequency of using the PASD, nor the amount of time that resident was to use the PASD.

In an interview two Resident Assistant's (RA) stated that the resident used the specific PASD for comfort.

A registered staff member shared that the specified resident used the PASD.

A Registered Nurse (RN) acknowledged that the PASD was not included in the specified resident's plan of care. The RN acknowledged that the PASD was being used during observations with the inspector.

Interview with Director of Resident Care (DRC) acknowledged that the PASD was not in the plan of care.

The Licensee has failed to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The severity of this non-compliance is a level 2, minimal harm/risk or potential for actual harm/risk and the scope is isolated. The home has a history of previous unrelated noncompliance. [s. 33. (3)]

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 a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the residents' plan of care, to be implemented voluntarily.

WN #6: 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 was 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.

Review of an Infoline Complaints identified that residents had not always received a shower or a bath twice a week. A specific resident reported that they and another resident had missed their scheduled bath when the bath Resident Assistant (RA) was moved to a different part of the home area when there was a staff shortage. They stated it happened quite frequently and affected other residents in their home area.

A review of the Residents' Council meeting minutes for a specific time frame, indicated that missed baths were a concern identified by the residents.

A review of the specified residents bath task list documented that the resident had missed baths on specific dates. An offer of a make-up bath was not provided.

A review of the second residents bath task list documented that the resident had missed a bath on a specified date, and waited until the next scheduled bath. The missed baths were acknowledged by Clinical Resource Nurse.

The Clinical Resource Nurse stated that registered staff were to note missed baths on the Missed Bath List in the nursing station.

A review of the Weekly Missed Bath List for the specified time period, indicated a total of 104 bathing sessions were missed for residents in the home and an offer of a make-up bath was not provided.

Director of Resident Care (DRC) stated that there was a contingency plan in place for unexpected staff shortages. Clinical Resource Nurse stated that when a RA called in and the scheduled shift could not be replaced by agency staff, then the bath RA may be pulled to fill that shift and resident baths were not always completed.

The Clinical Resource Nurse stated that all residents were to be bathed at least two times a week and in the case of the 104 missed baths during the specific time period that had not occurred.

The licensee has failed to ensure that each resident of the home was 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.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was a pattern. There was a compliance history of this legislation being issued in the home on May 12, 2015, issued as a Voluntary Plan of Correction (VPC) during complaint inspection, 2015-264609-0032, and October 21, 2014, as a Written Notice (WN) during the Resident Quality Inspection, 2014-229213-0066. [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 was 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.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have been retrained in the home's policy to promote zero tolerance of abuse and neglect of residents.

During the Resident Quality Inspection, record review of the home's training and retraining of the policy to promote zero tolerance of abuse and neglect of residents was done. The report from the online learning program was reviewed for the year 2016. The report showed that 177 out of 213 (89 per cent) staff were trained on the home's abuse and neglect policy. There were 14 staff off work that year and 22 staff that did not complete the training.

In an interview Director of Resident Care (DRC) stated that all staff be trained annually on the abuse and neglect policy. The DRC stated that they will develop a plan to ensure the training was completed.

Human Resources Coordinator (HRC), stated that they followed up on the compliance of staff who were required to do the annual training online. The HRC acknowledged that the report reviewed was accurate.

The licensee has failed to ensure that all staff have been retrained in the home's policy to promote zero tolerance of abuse and neglect of residents.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread. There was a compliance history of this legislation being issued in the home on November 2, 2015, as a Voluntary Plan of Correction(VPC) inspection, during Resident Quality Inspection #2015-260521-0050. [s. 76. (4)]

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 staff have been retrained in the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #8: 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 the plan of care set out clear directions to staff and others who provided direct care to the resident.

Observations were conducted during the Resident Quality Inspection. A specific resident was observed to have a specific PASD in place.

In an interview a Resident Assistant (RA) said that the specified resident used a PASD. The RA would expect to find the PASD in the resident's care plan and clear directions for use. The RA said the PASD would not impede the resident from movements.

Record review of the specific resident plan of care showed no documentation related to the use of this specific PASD.

In an interview with the Clinical Resource Nurse (CRN), they stated that if a resident had this PASD it should be included in residents' plan of care. The CRN agreed that the PASD was not included in the specific resident's plan of care, and stated the PASD should be included in the care plan.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 21, 2015, as a Voluntary Plan of Correction (VPC) during complaint inspection #2015-418615-0004 . [s. 6. (1) (c)]

WN #9: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within three business days after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A Critical Incident System (CIS) Report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC). The report indicated that a specified resident sustained a fall which resulted in a specified injury.

Documentation on Point Click Care indicated that Clinical Resource Nurse and Team Lead, Registered Nurse were made aware of the resident injury.

A review of the home's Critical Incidents Reporting Policy #RCM 3-3, stated that Critical Incident reporting was completed in keeping with the MOHLTC expectations and special attention was required to those incidents that involved a phone call to the MOHLTC and immediate completion of the Critical Incident report. This included immediate reporting using after hours phone and CIS completion for "an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status." In addition, all registered staff were required to know and understand the reporting expectations.

In an interview the Clinical Resource Nurse acknowledged that the home did not report the incident to the Ministry of Health and Long-Term Care until a specific date.

The licensee has failed to ensure that the Director was informed within three business days of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated. There was a compliance history of this legislation being issued in the home on April 21, 2015, as a Written Notice (WN) during complaint inspection #2015-418615-0004. [s. 107. (3.1)]

Issued on this 8th day of January, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY RICHARDSON (680), ADAM CANN (634), ALI NASSER (523), INA REYNOLDS (524)
Inspection No. / No de l'inspection :	2017_678680_0012
Log No. / No de registre :	017806-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 28, 2017
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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b).

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and a written record was kept.

Review of the home's Medication Incident/Near Miss reports and corresponding clinical records for a specified time frame were reviewed.

On a specified date, a medication incident occurred involving a specific resident. The report was missing documentation regarding root cause and contributing events that led to the medication errors.

In an interview a registered staff member stated that they were notified that they were involved in a medication incident on a specific date. The registered staff member said that one of the Team Leads explained the error to them on their next shift. The registered staff member stated that the Director of Care did not follow up with them to review what had happened. The registered staff member

stated that "nothing changed after this incident happened, it could totally happen again".

Interview was completed with Clinical Resource Nurse (CRN) and a Registered Nurse (RN) on a specified date. The RN stated that it was typically the responsibility of the Director of Care to complete the review and analysis section of medication incidents. The RN said that the Director of Care would fill out the back of the Medication Incident/ Near Miss report to complete the review, analysis and corrective action. The RN stated that the previous Director of Care would write on the back of "some of the medication incident forms but was not sure if they completed a review of all medication incidents."

Interview was completed with the former Director of Resident Care (FDRC) at the time of the above mentioned medication incidents. The FDRC stated that the responsibility for completing a full review and analysis of each medication incident was the responsibility of the Director of Resident Care (DRC). The FDRC said that they would base their decision to complete a review and analysis based on the effect on the resident and not if the resident was involved in the incident. The FDRC said that they would document the review and analysis on the Medication Incident/Near Miss report. The FDRC said that if the review and analysis was not completed on the back of the form then the review and analysis had not been completed.

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and a written record was kept.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread. The home has a history of previous unrelated noncompliance.
(634)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2018

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Tracy Richardson

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