Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 20, 2019	2019_648741_0027	021648-19	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

AYESHA SARATHY (741)

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): December 10 and 12, 2019

The following Critical Incident System (CIS) inspection was inspected as a part of this inspection:

CIS #M575-000025-19 related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with five Personal Support Workers (PSWs), a Registered Nurse (RN), the Nursing Team Leader, the Assistant Director of Care (ADOC), the Director of Resident Care (DRC) and the Administrator.

The Inspector also reviewed clinical records for an identified resident, the home's investigative notes related to the incident, and made observations in the home.

Inspector #115 was also present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that, when required to inform the Director of an incident

that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, a report in writing to the Director was made within 10 days of becoming aware of the incident, or sooner if required by the Director, setting out the following with respect to the incident: 2. A description of the individuals involved in the incident, including, ii. names of any staff members or other persons who were present at or discovered the incident; 3. Actions taken in response to the incident, including, v. the outcome or current status of the individual or individuals who were involved in the incident; 4. Analysis and follow-up action, including, ii. the long-term actions planned to correct the situation and prevent recurrence.

On an identified date, a Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care (MOLTC), related to the fall of a resident that resulted in the resident being transferred to the hospital and sustaining an injury.

The home amended the CIS report 23 days after the initial report was submitted, and added the following to the report:

- The name of the staff member who worked during the shift when the resident fell and checked on them last.
- The outcome and current status of the identified resident.
- The long-term actions that were taken by the home to prevent recurrence of a similar incident.

In an interview with the Personal Support Worker (PSW) who was identified in the CIS report to have last checked on the identified resident before their fall, they said they did not work the shift when the resident fell and had not seen the resident that day. Two PSWs who did work the shift when the resident fell were not identified in the CIS report and when interviewed separately, said that they were not spoken to as a part of the home's investigation into the resident's fall. A Registered Nurse (RN) and a PSW who were present at or discovered the fall were listed in the CIS report but said, during separate interviews, that they had not been interviewed as a part of the home's investigation.

During separate interviews, both the Director of Resident Care (DRC) and the Administrator said that the amended CIS report was submitted with inaccurate information pertaining to the PSW staff member who last checked on the resident before they had the fall. The DRC also said that the staff members who worked during the shift

when the resident fell were not interviewed as a part of the home's investigation into the incident. The DRC and Administrator acknowledged that the amendment to the CIS report should have been submitted to the MOLTC within 10 days of becoming aware of the incident and was submitted late.

The licensee failed to ensure that when the identified resident had a fall that resulted in being sent to the hospital and sustaining an injury, an amendment was made in writing to the Director within 10 days of becoming aware of the incident, setting out the names of the staff members who were present at the incident, the outcome or current status of the resident and the long-term actions planned to correct the situation and prevent recurrence.

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.