Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 28, 2023

Inspection Number: 2023-1583-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's

Long Term Care Home and City: Spruce Lodge Home for the Aged, Stratford

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2023.04.28 13:22:00 -04'00'

Additional Inspector(s)
Samantha Perry (740)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 13, 14, 17, 18, 19, 20, 24, 25, 2023.

The following intake(s) were inspected:

- Intake: #00007682, complaint with concerns related to responsive behaviours.
- Intake: #00013687, critical incident related to responsive behaviours.
- Intake: #00015757, complaint related to resident's falls, skin condition, menu planning and staff training.
- Intake: #00021584, critical incident related to a resident's fall.

The following intakes were completed in this inspection, intake: #00011330, #00012278 and #00015316 were related to falls.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident care needs were changed.

Rationale & Summary:
A complaint was reported to the Ministry of Long-Term Care by a family member. The complainant had resident care concerns specific to a resident's fall.

A review of the care plan with the Director of Care (DOC) showed the plan of care specific to certain interventions was not reviewed and revised after the resident had a fall and change in resident's care needs.

Sources: Clinical record review and staff interviews. [523]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the care set out in the plan of care for the resident was provided to the resident as specified in the plan specific to assistance in transfers.

Rationale & Summary:
A staff member was observed safely completing a transfer of a resident. That staff member reviewed the resident's plan of care with the inspector and said the resident transfer was not completed as per the plan of care.

In an interview the DOC reviewed the plan of care with the inspector and confirmed the care set out in the plan of care for the resident specific to certain interventions was not provided to the resident as specified in the plan.

Sources: Clinical record review, resident observation and staff interviews. [523]

The licensee has failed to ensure the care set out in the plan of care for the resident was provided to the resident as specified in the plan specific to food choices.

Rationale & Summary
A complaint was reported to the Ministry of Long-Term Care by a family member. The complainant had resident care concerns specific to a resident's nutritional choices. The complainant indicated that the resident cannot have a certain food choice and they requested from the home not to offer or provide the resident with that choice. The complainant reported that the home continued to provide the resident with that choice.

A clinical record review for the resident showed the following plan of care interventions directed staff not to provided the resident with this food choice. A progress note indicated that the resident was given that food choice for supper, had eaten one bite, and did not experience any side effects at that time.

In an interview the DOC said the care was not provided to the resident as specified in the plan of care.

Sources: Clinical record review, staff and resident interviews. [523]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 5.

The licensee has failed to ensure that all staff who provided direct care to the resident received, as a condition of continuing to have contact with the resident, training in palliative care.

Rational and Summary:
A complaint was reported to the Ministry of Long-Term Care by a family member. The complainant reported concerns related to lack of palliative care training for staff members who are providing care to the resident.

Interviews and record reviews showed that palliative training was not provided to all staff that provided direct care to the resident.

Sources: Training record review and staff interviews. [523]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)

The licensee has failed to ensure the staffing plan was based on the assessed care and safety needs of the residents.

Rational and Summary:
The Ministry of Long-Term Care received concerns related to the home's staffing plan.

A review of the home's staffing plan documented a change in the plan from three personal support staff members in multiple home areas on days and evenings to two personal support staff members on days and evenings.

Multiple staff members said they were concerned the residents' care and safety needs were not being met on the evening shift with the current staffing plan.

Management said there was no documented record of the residents' assessed care and safety needs before or after the staffing plan changed to support the home's decision or to monitor and evaluate the potential impact and risk of the staffing plan change to the residents' care and safety needs.

Sources: Interviews with staff and management, and the home's current staffing plan. [740]

WRITTEN NOTIFICATION: Training and orientation program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (3)

The licensee has failed to keep a written record relating to each evaluation of the training and orientation program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rational and Summary:
In an interview the Quality Improvement Lead and the DOC said the home did not have written record of the evaluation of the training and orientation program for 2022.

The Quality Improved Lead said they would be evaluating all the programs in the home and would ensure a written record of the evaluation was kept accordingly.

Sources: Staff interviews. [523]

WRITTEN NOTIFICATION: Designated lead

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 258

The licensee has failed to ensure that there was a designated lead for the training and orientation program.

Rational and Summary:
In an interview the Quality Improvement Lead and DOC said the home did not have a designated lead for the training and orientation program. They said they would ensure a designated lead would be assigned for the program as required.

Sources: Staff interviews. [523]