Ontario

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

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

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: January 9, 2025
Inspection Number: 2025-1583-0001
Inspection Type: Critical Incident Follow up
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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 8-9, 2025.

The following intakes were inspected:
- Intake: #00131117 - Critical Incident (CI) #M575-000025-24 related to a resident fall with injury
- Intake: #00132682 - Follow-up #: 1 - Compliance Order (CO) #001 from Inspection 2024-1583-0004

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1583-0004 related to O. Reg. 246/22, s. 12 (1) 2.

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure an incident that caused an injury to a resident, for which they were taken to a hospital and resulted in a significant change in their health condition, was reported to the Director no later than one business day.

Sources: review of CI #M575-000025-24 and resident health care records, and staff interviews.