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

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Public Report

Report Issue Date: July 25, 2025

Inspection Number: 2025-1583-0004

Inspection Type:
Complaint
Critical Incident

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 date(s): July 14-18, 22-23, 25, 2025

The following intake(s) were inspected:

- Intake #00150266 CI #M575-000005-25 Related to fall of a resident.
- Intake #00151911 Related to a complaint concerning care of a resident.

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Reporting and Complaints
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)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee failed to ensure when resident's care needs changed, the plan of care was revised. The resident required the re-implementation of specific care tasks, however, this change was not reflected in the plan of care.

Sources: Review of clinical records and staff interview.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (a)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision.

The licensee failed to update a resident's care plan when their treatment plan was

changed.The revised treatment plan was not consistently integrated into the care plan, and the resident's substitute decision-maker was not given the opportunity to fully participate in its implementation.

Sources: Complaint email, clinical records, investigation notes, and staff interview.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to forward to the Director either immediately or at any other time, a written complaint alleging a risk of harm to the resident.

Sources: Review of emails, CARES and LTChomes.net, and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a skin and wound assessment was completed for resident when multiple skin impairments were observed. The most recent skin assessment did not document the new skin concerns. Although staff were informed of the concern, no follow-up assessment was initiated.

Sources: Direct observation of resident, clinical records, and staff interviews.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, issued by the Director, was implemented. Specifically, section 9.1(e) of the IPAC Standard required, at minimum, additional precaution shall include; point-of-care signage indicating that enhanced IPAC measures were in place.

A resident was observed with an isolation cart outside their room, but no signage was posted to indicate additional precautions were in place. A staff member noted that signage was often missed and that the isolation cart had not been set up immediately after the resident's return from hospital. The IPAC Lead confirmed that signage and isolation setup should occur as soon as possible, as per the home's policy.

Sources: Direct observation, clinical records, and staff interviews.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1)
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that when they received a written complaint, concerning the care of a resident, that also alleged a risk of harm to the resident, that the home dealt with the complaint as follows:

1. The licensee failed to commence their investigation immediately
2. The licensee failed to provide a response to the complainants that included the Ministry's toll-free telephone number for making complaints and its hours of service, the contact information for the patient ombudsman under the Excellent Care for All Act, 2010, an explanation of what the licensee has done to resolve the complaint, and a confirmation that the licensee immediately forwarded the complaint to the Director, and
3. The licensee failed to communicate, when the licensee became aware that the investigation would not be completed in 10 business days, a date by which the complainant can reasonable expect a resolution, and a follow-up response detailing what the licensee has done so far to resolve the complaint.

Home's management acknowledged that the complaint was received, that alleged a risk of harm to a resident, the home's investigation was not commenced

immediately, and the home's response to the complainants within 10 business days and after 10 business days did not meet the legislative requirements.

Sources:

Review of complaint emails and internal communications, and staff interviews.