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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 12, 2016	2016_229213_0033	028257-16	Resident Quality Inspection

Licensee/Titulaire de permis

SPRUCEDALE CARE CENTRE INC
96 KITTRIDGE AVENUE EAST STRATHROY ON N7G 2A8

Long-Term Care Home/Foyer de soins de longue durée

SPRUCEDALE CARE CENTRE
96 KITTRIDGE AVENUE EAST STRATHROY ON N7G 2A8

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

RHONDA KUKOLY (213), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 19, 20, 21, 22, 23, 2016

Two critical incidents related to falls were inspected concurrently within the RQI:
Log #025135-16, critical incident #2946-000009-16
Log #006375-16, critical incident #2946-000001-16

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Care Coordinator, the Director of Environmental Services, the Director of Program Services, one Registered Nurse, four Registered Practical Nurses, seven Personal Support Workers, a Recreation Staff, a Laundry Aide, over 20 residents and four family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. 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 the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Residents' Council

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Resident #023 suffered an injury causing pain on an identified date.

A pain assessment was initiated in Point Click Care but was blank with no assessment information documented. No other pain assessments were documented in Assessments or Progress Notes in Point Click Care for a seven week period after the injury.

A Personal Support Worker #117 shared that they have observed resident #023 voice and exhibit non-verbal signs of pain during care since the injury.

Progress notes and medication administration records in Point Click Care indicated pain medication was administered on 32 occasions during the identified seven weeks.

The plan of care for resident #023 did not include pain as a focus or any interventions related to pain.

On September 22, 2016, the Director of Care #102 said that pain should have been assessed and the care plan updated for resident #023 after the injury. The Clinical Care Coordinator #103 said that a pain focus and interventions were not included in the plan of care for resident #023.

The home did not reassess resident #023's pain or update the care plan related to pain

when their pain needs changed. [s. 6. (10) (b)]

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

Progress notes for resident #004 indicated the resident suffered an injury causing a change in condition on an identified date.

During observations of resident #004, the resident was observed using an assistive device.

The current plan of care for resident #004 did not include an injury or that the resident was using the identified assistive device.

On September 21, 2016, the Clinical Care Coordinator (CCC) #103 acknowledged that the care plan had not been updated to reflect that the resident had an injury and should have been updated.

On September 21, 2016, the Director of Care (DOC) #102 acknowledged that the resident should have been reassessed and the plan of care updated with the change in resident #004's care needs related to the injury and the use of an assistive device.

The home did not update resident #004's care plan related to an injury or the use of an assistive device when these needs changed. [s. 6. (10) (b)]

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 the residents are reassessed and the plan of care reviewed and revised when residents care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The has licensee failed to ensure that the home's Pain Management policy was complied with.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) in Point Click Care (PCC) for resident #001, #003, and #004, showed that all three residents were experiencing pain.

The Pain Management Policy dated March 2016 indicated:
"Each resident must have a formal pain assessment on admission when triggered through the RAI MDS; RAI-MDS 2.0 assessments protocols and outputs will be reviewed in relation to pain and pain control with each new full pain assessment".

Resident #001 had an MDS assessment completed, it indicated that the resident had daily severe pain. Triggered pain assessments from the RAI MDS for resident #001 showed three pain assessments were overdue and not completed.

Resident #003 had an MDS assessment completed, it indicated that the resident had daily mild pain. A pain assessment was triggered from the RAI MDS and was overdue and not completed.

Resident #004 had an MDS assessment completed, it indicated the resident had pain less then daily with moderate pain. Assessments in PCC showed that two triggered pain assessments were overdue and not complete.

On September 21, 2016, the Clinical Care Coordinator #103 said that the triggered pain assessments should have been completed when the RAI MDS assessments were completed.

On September 21, 2016, the Director of Care #102 acknowledged that the pain assessments were not completed and should have been as per the pain management policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 the Pain Management policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident occurred, immediately reported the suspicion and the information upon which it was based, to the Director.

Progress notes for resident #004 indicated the resident suffered an injury during care, causing a change in condition on an identified date.

On September 21, 2016, the Administrator #101 acknowledged that they were aware of the incident and should have immediately reported the incident that caused the injury involving resident #004 to the Director and had not.

The home did not report an incident resulting in injury to resident #004 to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident occurs, immediately reports the suspicion and the information upon which it was based, to the Director, to be implemented voluntarily.

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.