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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2017	2017_538144_0053	027678-17	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

CAROLEE MILLINER (144), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 11, 12, 13, 14, and 15, 2017.

The following intakes were completed within the Resident Quality Inspection (RQI) :
031228-16 - IL-47662-LO - Complaint related to the plan of care.
017095-17 - IL_52057-LO - Complaint related to nursing and personal support services.
012188-17 - 2946-000008-17 - Critical Incident related to falls prevention and management.
021886-17 - 2946-000011-17 - Critical Incident related to falls prevention and management.
025609-17 - 2946-000014-17 - Critical Incident related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, the President of the Residents' Council, five family members, the Executive Director, Director of Care, Registered Dietician, Director of Program Services, six Registered Practical Nurses, six Personal Support Workers and one Housekeeping Aide.

During the course of the inspection, the inspector(s) toured the home, observed medication administration, medication storage areas, recreation activities and reviewed relevant resident clinical records, policies and procedures, the provision of resident care, resident to staff interactions, posting of required procedures and observed general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Sufficient Staffing

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

- **2 WN(s)**
- **1 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The home’s Restraint/PASD Policy last reviewed in June 2017, included the following directives for registered staff:
- Procedure: Assessment and Evaluation - "Include any/all alternatives that were tried/considered and why they were not suitable and obtain and record informed consent from the resident/substitute decision maker (SDM)."

On one identified date, a resident was observed by the inspector using a device that could have been considered a Personal Assistance Safety Device (PASD) or restraint.

A Registered Practical Nurse (RPN) told the inspector that the device in use by the resident was used as a PASD. The RPN further said that an assessment of the resident had not been completed related to alternatives to the use of a PASD.

Two Personal Support Worker's (PSW) shared with the inspector that the resident used the device at specific times during the day shift for an activity of daily living and that the device was used as a PASD.

The clinical record for the resident was reviewed by an inspector. The clinical record did not include an assessment of the resident for use of the observed device. The current care plan for the resident and progress notes did not include information related to use of the device.

The Director of Care (DOC) acknowledged that to date, nursing staff did not regard the device in use by the resident as a PASD or restraint and that alternatives to the use of the device had not been considered. The DOC advised that moving forward, it would be the expectation within the home to complete an assessment of each resident's needs related to considered use of the observed device. [s. 6. (2)]

2. A second resident was observed using a device that could have been considered a PASD or restraint.

One PSW said that staff used the device for the resident for an activity of daily living and knew that the resident required the device because they worked with the resident regularly. The PSW said that they thought that the plan of care should provide direction for staff who were not as familiar with the resident and that they did not recall seeing it in the resident's plan of care.

One Registered Practical Nurse (RPN) said that staff used the device for the resident as this resident would be unsafe without it. The RPN further said they thought that the resident had been assessed by nursing staff and the Physiotherapist to determine if the resident needed to use the device.

The RPN reviewed the clinical record for the resident and told the inspector that they did not find an assessment for the use of the device and that the use of the device was not included in the plan of care for the resident.

The clinical record for the resident was reviewed by the inspector and did not include a documented assessment regarding the use of the device in use by the resident.

The DOC and Resident Assessment Instrument (RAI) Co-ordinator said that the resident's condition had declined and that they thought the staff were using the observed device for safety and comfort. The RAI Co-ordinator said that the staff used the device at their discretion and that the use of the device had not been assessed by nursing staff as they thought an assessment was not necessary for use of this particular device.

The DOC reviewed the resident's clinical record and acknowledged that the device in use had not been assessed. The DOC also acknowledged that the use of the device was not included in the resident's plan of care.

The DOC reported that they had reviewed the home's Restraint/PASD policy and procedure and had spoken with the nursing staff regarding the use of the observed device for the resident. The DOC said that the use of the device needed to be assessed and included in the plan of care. The DOC acknowledged that the plan of care for the resident was not based on an assessment of the resident or the resident's needs regarding the device and this would be the expectation within the home moving forward. [s. 6. (2)]

3. One inspector observed a third resident using a device that could be considered a PASD or restraint.

One PSW said that the resident used the device for assistance with an activity of daily living and that use of this device did not tend to be in the plan of care for the residents in the home. The PSW said they would know whether the device could be used for a resident based on the resident's safety risk and what the resident seemed to need.

A review by the inspector of the clinical record for the third resident found that the clinical record did not include an assessment of or identification of the device in use and details or direction in the plan of care for staff regarding the use of the observed device.

The DOC reported that they had reviewed the home's Restraint/PASD policy and procedures and had spoken with the staff regarding the use of the observed device in the home. The DOC said that the use of the device needed to be assessed and included in the plan of care for the third resident. The DOC acknowledged that the plan of care for the resident was not based on an assessment of the resident or the resident's needs regarding the device and this would be the expectation within the home moving forward.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm. The scope was widespread during the course of the inspection. There was no history of related non-compliance with this legislation. [s. 6. (2)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the resident's Substitute Decision-Maker (SDM), if any, the Medical Director and the prescriber of the drug.

Review of the home's medication incident reports for July, August and September 2017, revealed that the following notifications had not been completed:

- On one identified date, one resident did not receive their medication as prescribed.The resident's clinical record was reviewed and did not include documentation related to the resident's SDM, the Medical Director (MD) and prescriber of the drug being notified of the medication omission.

- On another identified date, a second resident did not receive their medication as prescribed. The resident's clinical record was reviewed and did not include documentation that the resident's SDM, the MD and prescriber of the drug were notified of the medication omission.

The DOC acknowledged that in both of the above instances, the resident's SDM's, MD's and prescribers of the medications were not notified of the medication omissions and should have been.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's SDM, if any, the MD and the prescriber of the drug.

The severity of this issue was determined to be a level two as there as there was minimal harm or potential for actual harm. The scope was determined to be a pattern during the course of the inspection. There was no history of related non-compliance with this regulation. [s. 135. (1)]

Issued on this 21st day of December, 2017

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

Original report signed by the inspector.