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
Aug 3, 2018	2018_729615_0029	019514-18	Critical Incident System

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

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 2, 2018.

The following Critical Incident (CI) was inspected during this inspection:
CI 2946-000008-18/Log #019514 related to improper/incompetent treatment of a resident that resulted in harm.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC) and two Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed the resident, reviewed the resident clinical records, the home's investigative notes and relevant policies and procedures and other documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

On a specific date, the home submitted to the Ministry of Health and Long Term Care (MOHLTC) Critical Incident (CI) report #2946-000008-18/Log #019514-18 related to improper/incompetent treatment of a resident.

Review of the home's policy NS.07.01 Minimal Lift Policy dated June 2017, stated in part " A resident can not be left on the toilet hooked up to a sit/stand or hoyer lift with the brakes on. This is considered restraining a resident and this is not allowed".

A review of the CI and the resident's progress notes in Point Click Care (PCC) stated in part that the resident was left hooked up to the a lift (which is against the home's policy) while the 2 PSWs went to assist another resident. Both PSWs did not follow the care plan which stated that the resident was not to be left unattended while on the toilet. The resident was then found on the floor, hooked to the lift and had sustained an injury.

A review of the resident's current care plan stated in part "Resident not to be left unattended when on toilet due to increased risk for falls".

The resident was observed by the inspector on a specific date with the injury on their body.

During interviews, the DOC and two PSWs stated that leaving the resident attached to the lift unattended was a restraint and that the home's expectation would to not leave a resident attached to a lift as per their home policy. [s. 30. (1) 3.]

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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, 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 licensee has failed to ensure that where the home instituted or otherwise had in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

On a specific date, the home submitted to the Ministry of Health and Long Term Care (MOHLTC) Critical Incident (CI) report #2946-000008-18/Log #019514-18 related to improper/incompetent treatment of a resident that occurred the day before.

A review of the home's policy NS.16.02 Critical incidents dated July 21, 2018 stated in part "Role descriptions and actions to be taken. Registered Charge Nurse. Determine the timeframe during which the MOHLTC must be notified. If outside of business hours and the MOHLTC is to be notified immediately, then use the after hour pager and give details of the incident".

A review of the resident’s nursing progress notes, the day prior to the submission of the CI, stated in part that the resident had received improper or incompetent care that caused an injury.

Section 24. (1) of the Long Term Care Homes Act, 2007 states “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”.

During an interview, the DOC stated that the nurse working during the incident had called them at the time of the incident but all the details of the incident were not communicated to them. The DOC said that it was the day after that they realized that the improper care and injury of the resident had occurred. The DOC agreed that the incident was improper care that caused an injury and should have been reported immediately by the nurse to the MOHLTC. [s. 8. (1) (b)]

Issued on this 3rd day of August, 2018

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

Original report signed by the inspector.