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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 18, 2024
Inspection Number: 2024-1430-0002
Inspection Type: Critical Incident
Licensee: Sprucedale LTC LP by its general partners, Sprucedale LTC GP Inc. and RMI (Sprucedale) Inc.
Long Term Care Home and City: Sprucedale Care Centre, Strathroy

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15, 16, 2024.

The following intake(s) was inspected:
- Intake: #00126918 /CI#2946-000013-24 related to a resident fall

The following intake(s) was also completed:
- Intake: #00127491/CI#2946-000014-24 related to a resident fall

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for the resident related to falls prevention intervention was in place.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Director related to an unwitnessed resident fall.

As per the resident's care plan, one of the prescribed falls prevention interventions was the use of a call bell. The care plan specifically states that the call bell should be placed within the resident's reach.

During a resident observation, the inspector found that the call bell was not within the resident's reach. One of the Registered Nurses (RN) confirmed during the observation that the call bell should have been placed within resident's reach. In the presence of the inspector, RN repositioned the call bell making it reachable for the resident.

Sources:
Resident observation, record review , and interview with staff members

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Date Remedy Implemented: October 15, 2024

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