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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 24, 2014	2014_299559_0021	T-527-14	Critical Incident System

Licensee/Titulaire de permis

SPENCER HOUSE INC.
835 West Ridge Blvd, ORILLIA, ON, L3V-8B3

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

SPENCER HOUSE INC.
835 West Ridge Blvd., ORILLIA, ON, L3V-8B3

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

ANN HENDERSON (559)

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): September 22,23, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), nurse manager, charge nurse and personal support workers (PSWs).

During the course of the inspection, the inspector(s) reviewed clinical documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident had been identified in the written plan of care as a high fall risk resident. The resident had an unwitnessed fall and was transferred to hospital with a head laceration. When the resident returned to the home, a family member and nurse manager agreed a clip alarm should be used when the resident was in his/her chair, and added side rails when the resident was in bed in addition to the bed alarm already in place. Staff interviews confirmed that the clip alarm intervention was implemented. The resident had a further unwitnessed fall in his/her room; was transferred to hospital with a head laceration, wrist injury and suspected hip fracture and subsequently passed away. Staff interviews revealed no alarm was audible and the clip alarm was not found on the resident or on the resident's chair at the time of the fall. An identified PSW confirmed that the resident did not have a clip alarm applied when he/she was assisted into the chair. The administrator and DOC confirmed that the resident should have had a clip alarm in place. [s. 6. (7)]

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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 23rd day of October, 2014

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