Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

Name of Inspector:	Nancy Bailey	**Inspector ID #**	174
Inspection Report #:	2010_174_2971_13 Aug 171948		
Type of Inspection:	Complaint		
Licensee:	Spencer House Inc. 302 Town Center Blvd. Suite 200 Markham, Ontario L3R 0E8		
LTC Home:	Spencer House Inc. 835 West Ridge Blvd. Orillia ON L3V 8B3		
Name of Administrator:	Barb Pidgen		

To Spencer House Inc., your are hereby required to comply with the following order immediately as set out below:

Order #:	0001	**Order Type:**	Compliance Order, LTCHA 2007. SO 2007, c. 8, s. 6 (7)

Pursuant to: The Licensee has failed to comply with: LTCHA 2007. SO 2007, c. 8, 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)

Order:
The licensee must take the following actions:
1. The front line staff must consistently implement the plan of care for an identified resident.

Grounds:
The plan of care for a resident provided direction to staff providing care:

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These directions were not carried out on a specified date resulting in harm to a resident.

This order must be complied with by:	Immediately

IO – 08/12 4:20 pm

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 19th day of October, 2010.	
Signature of Inspector:	Nancy A Bailey
Name of Inspector:	Nancy A. Bailey
Service Area Office:	Toronto

Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
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Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 16, 2010	2010-174-2971-13Aug 171948	Complaint log # TO0673

Licensee/Titulaire
Spencer House Inc.
302 Town Center Blvd.
Suite 200
Markham, Ontario
L3R 0E8

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(s)
Nancy Bailey (ID # 174)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding an alleged assault.

During the course of the inspection, the inspector spoke with: Director and Assistant Director of Care, Registered and Non- Registered staff, residents

During the course of the inspection, the inspector: conducted clinical record reviews, toured home areas as applicable.

The following Inspection Protocols were used in part or in whole during this inspection:

- Responsive Behaviours Inspection Protocol
- Personal Support Services Inspection Protocol
- Critical Incident Response Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC
1 CO: CO # 0001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* a trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de « exigence prévue par la présente loi » au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007. SO 2007, c. 8, 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:

The plan of care for a resident provided direction to staff providing care.
These directions were not carried out on a specified date resulting in harm to another resident.
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Inspector ID #:	174

Additional Required Actions:

CO # 0001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form

WN #2: The Licensee has failed to comply with LTCHA 2007. SO 2007 c.8, s. 6 (1) c.
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1) c.

Findings:

1. The plan of care for a resident did not include clear directions regarding monitoring for safety.

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8, s. 6 (1) **the licensee is hereby requested to prepare a written plan of correction for achieving compliance regarding providing clear directions to staff in relation to monitoring a resident . LTCHA 2007. SO 2007 c.8, s6 (1) c to be implemented voluntarily**.

Inspector ID #:	174

WN #3: The Licensee has failed to comply with O. Reg.79/10, s.107(2).
Where a licensee is required to make a report immediately under subsection (2) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hour's emergency contact.

Findings:

1. The Long Term Care Home did not immediately report the incident to the MOHLTC.

Inspector ID #:	174

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection).