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
Jun 22, 2018	2018_638609_0013	008623-17, 022641-17, 023693-17, 004007-18, 005348-18	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
835 West Ridge Blvd. ORILLIA ON L3V 8B3

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

CHAD CAMPS (609)

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): June 5-8 and 11-15, 2018.

This inspection was conducted as a result of:

Three Critical Incident (CI) reports the home submitted to the Director related to resident falls;

One CI report the home submitted to the Director related to resident to resident abuse; and

One CI report related to the hospitalization of a resident.

A Follow Up inspection #2018_638609_0011 and a Complaint inspection #2018_638609_0012 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Resident Programs, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members of residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staff training records, internal investigations, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Responsive Behaviours

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

1 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; as well as identifying and implementing interventions.

A Critical Incident (CI) report was submitted by the home to the Director, which outlined how on a particular day, resident #001 was involved in an altercation with resident #007 which caused an injury to resident #007.

The CI report indicated the prior to the incident, resident #001 had exhibited no other altercations with other residents.

Inspector #609 reviewed resident #001's healthcare records for the six months prior to the CI report and found in progress notes an identified number of separate incidents where the resident was responsive towards other residents.

Then, in another progress note, RN #104 indicated that they had notified the DOC of resident #001's responsive behaviours and altercations.

A review of resident #001's Minimum Data Set (MDS) assessment indicated that the resident displayed responsive behavior which was not easily altered.

A further review of resident #001's healthcare records for the six months prior to the CI report found that the resident's medications were altered no less than an identified number of times related to increasing responsive behaviours.

Despite all the above cited information related to resident #001's responsive behaviours, a review of the resident's entire plan of care history report found no identification of triggers or interventions to manage the resident's responsive or threatening behavior towards co-residents.

a) A review of the home's policy titled "Responsive Behaviours- Management" current revision March 2018 required registered staff to:

-Determine if a resident's responsive behaviours were endangering others;
-Strategize with the team on the risk level, causes, triggers and any additional interventions that were required;
-Refer to available resources in the care community such as Behavioural Supports Ontario (BSO) or psychogeriatric resource team; and
-Monitor and evaluate new or changed antipsychotics/analgesics, antidepressants and mood stabilizers.

During an interview with RN #104, they verified that they were present and working on a particular day when they were notified that resident #001 threatened a resident. On another particular day when resident #001 was involved in altercation another resident, as well as on the day of the CI report, when the resident was involved in an altercation with resident #007.

The RN was unable to describe how they assessed that resident #001's behavior was not endangering others. The RN denied strategizing any additional interventions, updating the care plan, or making any BSO or psychogeriatric referrals. The RN further denied any evaluation of resident #001's behaviour with changes to their responsive behavior medications as required by the home's policy.

b) A review of the home's policy titled "Responsive Behaviours- Management" current revision March 2018 required staff to use an interdisciplinary approach and work together to identify possible triggers for responsive behaviours. The DOC was also to determine if additional staffing supports were required.

During an interview with the DOC, they denied the validity of RN #104's progress note

that they were ever notified of resident #001's responsive behaviours, or any awareness of resident #001's responsive behaviours towards co-residents. This was despite indicating that high risk situations (which included altercations between residents) would have been reviewed at their daily manager's meeting.

A review of resident #001's care plan and progress notes for the six months prior to the CI report was conducted with the DOC. The DOC verified that the information should have been used to ensure steps were taken and care-planned to minimize the risk of altercations between resident #001 and co-residents and that this did not occur. [s. 54.]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; as well as identifying and implementing interventions, to be implemented voluntarily.

Issued on this 1st day of August, 2018

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

Original report signed by the inspector.