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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2018	2018_746692_0019	006508-18, 008175-18, 010498-18, 010649-18, 015257-18, 025834-18, 026910-18	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

SHANNON RUSSELL (692)

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): December 10-14, 2018

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-One intake, related to an adverse medication reaction causing a transfer to the hospital.
-Two intakes, related to alleged resident to resident abuse.
-Four intakes, related to resident falls with injury.

A Follow up inspection #2018_746692_000020 was conducted concurrently with this Critical Incident System inspection.

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

The Inspector also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as the licensee's policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified within 10 days of becoming aware of an incident, or sooner if required by the Director, to include the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident Report (CIR) was submitted to the Director, in which the licensee reported an incident that caused an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

The CIR identified that PSW #109 reported that resident #003 had sustained a fall resulting in them acquiring an identified injury. Resident #003 was transferred to the hospital on an identified date in which they were diagnosed with an identified injury and returned to the home the following day.

A further review of the CIR revealed the licensee failed to provide the long-term actions that were to be implemented upon the return to the home of resident #003 from the hospital. The Director requested the licensee to provide an amendment outlining the actions taken in order to prevent recurrence of falls for resident #003, which was not completed by the licensee.

In an interview with the Executive Director (ED) and Director of Care (DOC), they stated that they did not amend the CIR when resident #003 was readmitted to the home providing the required information of what actions would be taken in order to correct the situation and to prevent recurrence. The ED and DOC both confirmed that the CIR should have been amended upon resident #003's return from the hospital. [s. 107. (4) 4.]

Issued on this 20th day of December, 2018

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

Original report signed by the inspector.