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

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
Telephone: (800) 663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date: November 9, 2022	
Inspection Number: 2022-1454-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Spencer House Inc.	
Long Term Care Home and City: Spencer House, Orillia	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature** Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2022.11.18 10:49:33 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 24-28, 2022

The following intake(s) were inspected:

- One intake, which was a complaint related to the care of a resident
- One intake, which was related to a disease outbreak

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

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: O. Reg 246/22, s. 102 (11) (a)

The licensee has failed to ensure the home's written plan for responding to disease outbreaks was complied with.

As per s.11 of Fixing Long Term Care Act (FLTCA), the home is required to have a written plan for responding to disease outbreaks, and to ensure the plan is complied with.

Specifically, the licensee did not comply with the policy titled "Defining an Outbreak-Respiratory and Enteric, dated October 2022, which was captured in the home's IPAC program. The policy stated that upon declaration of a disease outbreak, the home was to post signage related to the outbreak at the entrance to the care community.

Upon entering the home, the Inspector did not observe any signage posted at the entrance to the home related to the respiratory outbreak that was occurring in the home.

The IPAC lead confirmed that the home was still in an active respiratory outbreak facility wide and there had been signage posted on the door, and that it may have been mistakenly removed. The Inspector noted signage signifying the respiratory outbreak on the entry door to the home the following day.

Sources: Observations on October 24, and 25, 2022; the home's policy titled "Defining an Outbreak-Respiratory and Enteric IX-F-10.00 (a), dated October 2022; interviews with the IPAC Lead, and the DOC.

[690]

Date Remedy Implemented: October 25, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of a resident's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Information was provided to the home related to a consult that occurred for a resident with a Physician from an external health care facility on an identified date, that included recommendations for specified medications and follow up. The recommendations were not fully implemented and no one from the home contacted the external agency to discuss the recommendations until approximately two months later.

Registered staff and the DOC could not explain why there was a delay in obtaining further information from the external health care facility related to the recommendations.

Sources: A resident's health records; Investigation notes; interviews with Registered staff; the Physician; and DOC

[690]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's Substitute Decision maker (SDM) was informed that there had been some changes to the resident's medication orders, but was not provided with all the information related to the changes.

An RN, and the DOC verified that the SDM was not provided with all the information related to the changes in medications dosage and duration of the medication until after the medications were

administered to the resident and therefore, were not provided an opportunity to fully participate in the implementation of the plan of care.

Sources: Investigation notes related to care concerns of a resident; Interviews with Registered Staff, and the DOC.

[690]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that care was provided to a resident, as specified in the plan of care.

A resident's care plan identified that the resident had an intervention in place for staff to follow to assist the resident with an identified Activity of Daily Living (ADL).

During an observation, the Inspector noted that a PSW was providing assistance for the ADL, and was not using the specified intervention as indicated in the care plan.

The PSW stated that they were aware of the intervention, however they had not used them that day. The DOC stated that staff were expected to provide care as per the care plan and use the specified intervention, as outlined in the resident's care plan.

Sources: Observations of the resident; a resident's care plan; Documents in the resident's health records; Interviews with the PSW, RD, and the DOC.

[690]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (5) 1.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a

disease of public health significance, or communicable disease as defined by the Health Protection and Promotion Act.

A critical incident (CI) report was submitted to the Director for a disease outbreak four days after the outbreak was declared

The IPAC lead confirmed that the outbreak was not immediately reported to the Director, as they had thought the DOC had submitted the report. The DOC stated that they had not submitted the CI report immediately as they were unsure if the report was required.

Sources: A CI report; Interviews with the IPAC Lead, and the DOC.
[690]

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

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
Telephone: (800) 663-6965
SudburySAO.moh@ontario.ca