Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Original Public Report

Report Issue Date: May 25, 2023	
Inspection Number: 2023-1454-0002	
Inspection Type: Critical Incident System	
Licensee: Spencer House Inc.	
Long Term Care Home and City: Spencer House, Orillia	
Lead Inspector Shannon Russell (692)	**Inspector Digital Signature** Shannon K Russell Digitally signed by Shannon K Russell Date: 2023.06.01 10:05:56 -04'00'
Additional Inspector(s) Jessamyn Spidel (000697)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9-11, 2023.

The following intake(s) were completed:

- Two intakes, which were related to incidents of resident-to-resident responsive behaviours, resulting in a risk of harm to the residents; and,
- Two intakes, which were related to residents sustaining falls, resulting in a significant change in health status.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, was immediately reported to the Director.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director, which identified that two days previous, there had been an unwitnessed physical altercation between two residents, which resulted in one of the residents sustaining an injury. The Director of Care (DOC) acknowledged that the incident should have been reported to the Director the day the incident occurred, by reporting the incident to the after-hours contact, and then the CIS would be submitted after obtaining the information.

Failure to report to the Director as required had no impact on and had not presented a risk to the residents' health, safety, or quality of life.

Sources: CIS report; residents' health care records; interviews with the DOC and other staff. [692]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 54 (b)

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, and implementing interventions for residents exhibiting responsive behaviours.

Rationale and Summary
(a) A Personal Support Worker (PSW) overheard an unwitnessed altercation between two residents. At the time of the incident, the one resident was to have a specified intervention in place; however, the specified intervention had not been implemented at the time of the incident.

Direct care and Registered staff verified that the resident was to have had the specified intervention in place at the time of incident, due to a history of responsive behaviours. The Associate Director of Care (ADOC) and DOC both identified that the specified intervention was to have been always in place to prevent altercations and mitigate the risk to all residents.

There was a low impact and a moderate risk for not implementing the specified intervention continuously for the resident due to their responsive behaviours to mitigate risk towards others.

Sources: CIS report; residents' health care records; the home's internal investigation notes; the

home's policy titled, "Responsive Behaviours Management, VII-F-10.10", last revised November 2022; and interviews with direct care staff, the ADOC, and the DOC. [692]

(b) A resident had exhibited a specific responsive behaviour towards another resident. As a result, a specified intervention was implemented for the resident, as another strategy to prevent further inappropriate responsive behaviours.

The resident's progress notes indicated that two days after the specified intervention was implemented, the resident had been found demonstrating a specific responsive behaviour towards another resident; the note indicated that the specified intervention was not in place at the time of the incident. Registered staff, the ADOC and DOC indicated that at the time of the second incident the resident was to have always had the specified intervention in place, and they did not.

There was a low impact and a moderate risk for not implementing the specified intervention continuously for the resident due to their responsive behaviours to mitigate risk towards others.

Sources: CIS report; residents' health care records; the home's internal investigation notes; the home's policy titled, "Responsive Behaviours Management, VII-F-10.10", last revised November 2022; and interviews with direct care staff, the ADOC, and the DOC. [692]