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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2018	2018_657681_0020	021931-18	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

STEPHANIE DONI (681)

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): August 22 - 24, 2018.

The following intake was inspected on during this Critical Incident System inspection:
- One intake related to the unexpected death of a resident.

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

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident (CI) report was submitted to the Director related to the unexpected death of resident #001. The CI report indicated that on a particular date and time, resident #001 was found unresponsive and a specified device was found to not be functioning correctly.

Inspector #681 reviewed the progress notes in resident #001's electronic medical record, which included a progress note entered by RPN #105 after the resident's death. The progress note indicated that RPN #105 was advised by PSW #106 that resident #001 was expressing concern about their specified device and requested to be switched from one specified device to their other specified device. RPN #105 advised PSW #106 that they could switch resident #001 to their other specified device and that they were to check the resident every 15 to 20 minutes. The progress note further indicated that PSW #106 contacted RPN #105 a short time later to advise them that resident #001 continued to use their original specified device and had not been switched to their other specified device. At a specified time on that same date, RPN #105 received another call from PSW #106 advising them that resident #001 again requested to be switched to their other specified device and that PSW #106 had made this switch. The progress note indicated that at a later time on the same date, PSW #106 had RPN #105 check on resident #001. The resident was found unresponsive, vital signs absent, and the resident was using their original specified device. PSW #106 advised RPN #105 and RN #111 that they last checked on resident #001 one hour and 40 minutes ago. PSW #106 stated that when they went to check on resident #001 again, they found the resident unresponsive and that their other specified device was not functioning correctly so PSW #106 switched the resident back to their original specified device.

The Inspector reviewed resident #001's medical record, which indicated that resident #001 was to use the original and other specified devices.

The Inspector reviewed another progress note in resident #001's medical record, which was entered by RPN #104 on an earlier date. The progress note indicated that, on this date, resident #001 was experiencing specific symptoms while using the specified device and RPN #104 completed specified nursing measures.

During an interview with RPN #104, they indicated that resident #001 was concerned about a specific aspect of their care related to the device and that staff would frequently complete a specified nursing intervention to reassure the resident.

The Inspector reviewed resident #001's electronic medical record, which indicated that a specified nursing intervention in relation to the device was last completed on a prior specified date and that there was no documentation to indicate that the nursing intervention had been completed on the date of resident #001's death.

During an interview with PSW #106, they indicated that resident #001 was supposed to receive a specified intervention related to the device and that the resident was often concerned about this intervention. PSW #106 stated that on a particular date and time, resident #001 called them because they wanted to be switched to their other specified device. PSW #106 stated that resident #001 called again at a later time on the same date and requested to be switched to their other specified device for a second time. PSW #106 stated that they spoke with RPN #105 twice on the specified date and RPN #105 advised PSW #106 to switch the resident from one specified device to their other specified device. PSW #106 stated that they switched the resident to their other specified device and went back to check on the resident a half hour later. PSW #106 stated that RPN #105 did not provide any direction about how frequently resident #001 should be checked. PSW #106 also indicated that they were not aware of the length of time that the resident's other specified device would function. PSW #106 stated that they went to check on the resident again approximately one hour and 30 minutes later and found the resident unresponsive and the resident's device not functioning correctly.

During an interview with RPN #105, they indicated that they did not recall seeing or checking on resident #001 during a specific two hour and 10 minute time period. RPN #105 stated that, prior to resident #001's death, they were not aware of the length of time that resident #001's other specified device would function. RPN #105 indicated that they advised PSW #106 to check resident #001 every 15-20 minutes because they knew that the other specified device would function "at least that long".

Inspector #681 reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident", last revised January 2015, which indicated that all residents have the right to dignity, respect, and freedom from abuse and neglect and that abuse and neglect were not tolerated in any circumstances.

During an interview with the DOC, they indicated that if a resident expressed concern with their specified device not working correctly, they would expect registered staff to complete an assessment of the resident and the device as soon as possible and, if necessary, contact the physician and/or a specified external company. The DOC also stated that they would expect that staff, who were providing direct care to resident #001, be aware of how long the resident's specified device would function. The DOC stated that staff had access to a particular document that identified the length of time that various specified devices would function. The DOC indicated that after the resident was switched from their original specified device to their other device, they should have been checked every 15 to 30 minutes. The DOC acknowledged that resident #001 was not checked for a period of one hour and 40 minutes and that this exceeded the time that would be expected. The DOC also verified that resident #001 should have had a thorough assessment done by registered staff as soon as possible, and that this assessment was not completed.

The licensee has failed to ensure that residents were not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CI report was submitted to the Director related to the unexpected death of a resident. Please refer to WN #1.

Inspector #681 reviewed resident #001's medical record, which indicated that the resident was to utilize a specified device. The Inspector also reviewed resident #001's electronic care plan, which indicated that the resident was to utilize the same specified device.

During an interview with PSW #106, they indicated that resident #001 was to utilize a specified device. PSW #106 stated that on a particular date and time, they switched the resident from one specified device to their other specified device. PSW #106 stated that they went back into resident #001's room at a later time and found the resident unresponsive and that their specified device was not functioning correctly.

During an interview with RN #111, they stated that on a particular date, PSW #106 went to check on resident #001 and found that the resident's specified device was not functioning correctly. RN #111 stated that PSW #106 called the RPN and switched the resident back to their original specified device because, at that time, PSW #106 was not aware that the resident was deceased. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Issued on this 21st day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2018_657681_0020
Log No. / No de registre :	021931-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 20, 2018
Licensee / Titulaire de permis :	Spencer House Inc. 835 West Ridge Blvd, ORILLIA, ON, L3V-8B3
LTC Home / Foyer de SLD :	Spencer House 835 West Ridge Blvd., ORILLIA, ON, L3V-8B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Traci VanGrinsven

To Spencer House Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) ensure that all residents are not neglected by the licensee or staff.

b) develop and implement a process to ensure that staff are familiar with the use and functional status of specified devices used by residents.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

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PSW #106 that resident #001 was expressing concern about their specified device and requested to be switched from one specified device to their other specified device. RPN #105 advised PSW #106 that they could switch resident #001 to their other specified device and that they were to check the resident every 15 to 20 minutes. The progress note further indicated that PSW #106 contacted RPN #105 a short time later to advise them that resident #001 continued to use their original specified device and had not been switched to their other specified device. At a specified time on that same date, RPN #105 received another call from PSW #106 advising them that resident #001 again requested to be switched to their other specified device and that PSW #106 had made this switch. The progress note indicated that at a later time on the same date, PSW #106 had RPN #105 check on resident #001. The resident was found unresponsive, vital signs absent, and the resident was using their original specified device. PSW #106 advised RPN #105 and RN #111 that they last checked on resident #001 one hour and 40 minutes ago. PSW #106 stated that when they went to check on resident #001 again, they found the resident unresponsive and that their other specified device was not functioning correctly so PSW #106 switched the resident back to their original specified device.

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from their original specified device to their other device, they should have been checked every 15 to 30 minutes. The DOC acknowledged that resident #001 was not checked for a period of one hour and 40 minutes and that this exceeded the time that would be expected. The DOC also verified that resident #001 should have had a thorough assessment done by registered staff as soon as possible, and that this assessment was not completed.

The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The severity of this issue was determined to be a level three, as there was the actual harm/risk to resident #001. The scope of the issue was a level one, as it only related to one resident reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

-compliance order (CO) issued November 6, 2017, with a compliance due date (CDD) of December 29, 2017, (#2017_414110_0010). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2018

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Stephanie Doni

Service Area Office / Bureau régional de services : Sudbury Service Area Office