



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date de l'inspection May 18, 20,23, 24, 2011	Inspection No/ d'inspection 2011_174_2971_18May102230	Type of Inspection/Genre d'inspection CIS Inspection Log T-1278-11 Log T-2172-10 Follow up to: 2010_174_2971_13Aug171948
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Licensee/Titulaire
Spencer House Inc., 835 West Ridge Blvd., Orillia, ON, L3V8B3

Long-Term Care Home/Foyer de soins de longue durée
Spencer House Inc., 835 West Ridge Blvd., Orillia, ON, L3V8B3

Name of Inspector/Nom de l'inspecteur
Nancy Bailey Inspector # 174

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct follow up inspections to CIS reports.

During the course of the inspection, the inspector(s) spoke with: Administrator, Director of Care, Registered staff, PSW staff

During the course of the inspection, the inspector(s): Toured the units including the dining room and lounges.

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation Inspection Protocol
Minimizing of Restraining Inspection Protocol
Responsive Behaviours Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCH Act 2007, c.8, s.6(1) c
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1) c.

Findings:

- The documented plan of care for an identified resident with responsive behaviours did not provide clear direction to staff.

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Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s. 6(1) c the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the plan of care for responsive behaviours for an identified resident sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 30(2)
The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

- There was no assessment documentation regarding an incident of resident to resident abuse,

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VPC - pursuant to, **O. Reg. 79/10, s. 30(2)** the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.



WN #3: The Licensee has failed to comply with O. Reg. 79/10, s82(1)(b)(c)
Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(b) attends regularly at the home to provide services, including assessments; and
(c) participates in the provision of after-hours coverage and on-call coverage.

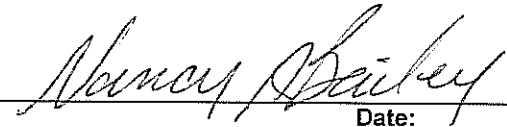

Findings:

- Following an incident of resident to resident abuse an attending physician was not available for contact and had not advised the home of an on call schedule. The resident was not reassessed by a physician for possible effects from the incident.

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**CORRECTED NON-COMPLIANCE
Non-respects à Corrigé**

REQUIREMENT EXIGENCE	TYPE OF ACTION/ ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
LTCH Act 2007, SO 2007, c.8, s.6(7)	CO	0001	2010_174_2971_13Aug171948	174

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.	
			
Title:	Date:	Date of Report: (if different from date(s) of inspection).	