Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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 20, 2019	2019_565647_0032	019898-19, 020729-19, 020742-19, 022543-19	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

JENNIFER BROWN (647), 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 2 - 6, 2019.

The following intakes were completed in this Critical Incident System inspection (CIS):

-one log related to neglect,
-two logs related to resident to resident abuse, and
-one log related to a fall with injury.

Complaint inspection #2019_565647_0031 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director(s) of Care (ADOC), Nurse Manager (NM), Resident Relations Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Clinicians from an external agency, residents, and substitute decision makers (SDM).

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director for an incident of resident neglect. A review of the CIS report, by Inspector #692, indicated that resident #004 had been provided with a specified intervention that was not removed for over a two-hour period.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) 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".

Inspector #692 reviewed the home's internal investigation notes, that identified an incident report, completed by Registered Nurse (RN) #106, which indicated that Registered Practical Nurse (RPN) #101 had provided resident #004 the specified intervention at a specific time, and had advised Personal Support Worker (PSW) #105 that they had to check the resident. Approximately two hours later, RN #106 was notified by the RPN, that resident #004 had been found with the provided specified intervention for an unknown period of time, and had developed redness to a specified area. A further review of the investigation notes identified two staff members received disciplinary action for being neglectful towards resident #004, and not adhering to the home's policy.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident, #VII-G-10.00", last revised April 2019, indicated that the home had a zero tolerance for resident abuse and neglect, which would not be tolerated in any circumstance by anyone.

During an interview with PSW #105, they indicated to Inspector #692 that they had been

the staff member who provided the specified intervention to resident #004. PSW #105 indicated that they had not recalled that RPN #101 told them that they had provided resident #004 with the specified intervention, therefore they had not checked them and had not removed the specified intervention.

Inspector #692 interviewed RPN #101, who indicated that they had provided resident #004 with the specified intervention at an identified time, and told PSW #105 what they had done, and to check them. RPN #101 indicated that resident #004 had not been checked by PSW #105 until approximately two hours later, at which time it had been discovered that the specified intervention was still in place, and the resident had developed redness to an identified area. RPN #101 identified that they had neglected to provide resident #004 with the care that they had required.

In an interview with RN #106, they indicated to Inspector #692 that at an identified time, they had been notified by RPN #101 that resident #004 had been found with a specified intervention and had redness noted to an identified area. The RN identified that they had begun an investigation and it had been determined that resident #004 had been left with the specified intervention in place for a two-hour period. RN #106 indicated that this action was neglectful towards resident #004 and that staff had not followed the home's policy for zero tolerance of neglect.

Inspector #692 interviewed Associate Director of Care (ADOC) #116, who identified the home had a zero tolerance of resident abuse and neglect policy that was to be followed by anyone interacting with the residents. ADOC #116 confirmed that the incident in which resident #004 had been provided a specified intervention for two hours that caused an injury, did meet the definition of neglect, and that RPN #101 and PSW #105 had violated the home's abuse and neglect policy. [s. 20. (1)]

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 homes written policy to promote zero tolerance of abuse is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident who demonstrated responsive behaviours, the behavioural triggers for the resident were identified.

A CIS report was submitted to the Director regarding incidents of resident to resident abuse that occurred on an identified day, and again, the following day, that both involved resident #002.

A review of the health records for resident #002, by Inspector #647, included the progress notes, indicated that resident #002 had consistently required a specified intervention as they had consistently refused an identified activity of daily living, and would appear to be agitated at unpredictable times. As a result of the ongoing resistance to the identified activity of daily living, and the new responsive behaviour, the home had referred the resident to an identified external agency.

An assessment from the identified external agency, had been reviewed by the Inspector. The document indicated that after the assessment of resident #002, it had been determined that they were able to identify a specific trigger for their responsive behavior.

A review of the current plan of care by Inspector #647, identified a specific focus, however, did not include the identified trigger that caused the resident to exhibit the responsive behaviour.

During an interview with PSW's #107 and #110, they indicated that their Kardex provided them with high level information on the safety and care needs of each resident. The Inspector reviewed resident #002's Kardex with these staff members, who indicated there was not a trigger identified as a cause of the responsive behavior for resident #002.

During an interview with RPN #108, they indicated that they were the full time registered staff member on the home area and was very familiar with the care needs of resident #002. RPN #108, indicated to the Inspector that they were aware of the identified trigger that resident #002 would exhibit prior to exhibiting a responsive behaviour. Once the registered staff had provided the resident with a specified intervention, the resident would settle. The RPN further indicated that since the identified trigger that was a cause for resident #002 to exhibit the responsive behaviour was not in the plan of care, other staff may not be aware of the intervention.

During an interview with a clinician from the external agency, they indicated that they were considered to be part of the health care team. The external agency indicated that any identified trigger should be included in the resident's plan of care to assist staff in the management of resident #002's responsive behaviours.

During an interview with the Director of Care (DOC), they indicated the identified trigger for resident #002's responsive behaviour and should be identified on the plan of care. [s. 53. (4) (a)]

2. The licensee has failed to ensure that strategies were developed and implemented to the resident, who demonstrated responsive behaviours.

A further record review from Inspector #647, of the health records, that included the progress notes indicated that resident #002 had consistently required a specified intervention, and had consistently refused a specified activity of daily living. As a result of the ongoing resistance and the new responsive behaviour, the home had referred the resident to the external agency.

A review of the current plan of care identified a specified focus, with related interventions.

A document titled "Initial Assessment", from the external agency was reviewed by

Inspector #647. This document identified that resident #002 was less compliant with an identified activity of daily living during a specified time.

A review of the documentation related to the specified activity of daily living, indicated that resident #002 was scheduled to receive a specified intervention at a specified time. A review of this documentation for the previous 30 days, indicated that resident had refused this specific intervention 50 per cent of the time.

During an interview with the external agency, they indicated that they were considered to be part of the health care team. Once a resident was referred to them, they observed and assessed the resident, spoke with all disciplines of staff, and assisted the home in developing strategies and interventions to be implemented into the resident’s plan of care.

During an interview with PSW’s #107, and #110, they indicated that resident #002 often refused a specified activity of daily living and would exhibit a responsive behaviour that staff were unable to redirect.

During interviews with RPN's #104, #108, and RN #102, they acknowledged the external agency was used when the home needed assistance with managing the behaviours of an identified resident. When the Inspector asked these staff members, if the recommended strategies had been considered or implemented as per the recommendations from the clinician, they indicated that they had not been.

During an interview with the DOC, they were unaware if any discussion had taken place related to the strategy identified to provide the specified activity of daily living to resident #002 at a different time. The DOC had indicated that the strategies developed by the interdisciplinary team should be implemented to respond to the resident’s responsive behaviours. [s. 53. (4) (b)]

3. The licensee has failed to ensure that residents response to interventions were documented.

A further record review of the health records, by Inspector #647, that included the progress notes indicated that resident #002 had one previous identified responsive behaviour towards another resident.

A review of the actions by the home to investigate the change in behaviour included a

specified intervention for a specified period. The specified intervention had been initiated related to the new responsive behaviours towards co-residents.

A review of the specified intervention indicated that resident #002 was required to be observed and documentation completed in specified intervals. Inspector #647 reviewed the specified intervention for resident #002, which indicated a lack of documentation at specified times throughout the identified period of time.

The two incidents of responsive behaviours that occurred on two consecutive dates, triggered the home to initiate the specified intervention again, for an identified period of time. A review of the specified intervention, indicated that resident #002 was required to be observed and documentation completed in specified intervals. Inspector #647 reviewed the specified intervention for resident #002, starting on an identified date, which indicated a lack of documentation at specified times throughout the identified period of time.

The Inspector interviewed PSW's #107 and #110, who indicated that is was usually communicated to them during shift change, if the specified intervention was required for a particular resident and that it was the responsibility of the PSW’s to complete it for the required intervals. These PSW's further indicated that there were no other areas to document this specified intervention and if there were blank areas on the form, that indicated the assigned PSW's did not document as required.

The Inspector interviewed Nurse Manager (NM) #102, who indicated that the identified intervention was for any resident who had a change in behavior that the home was trying to figure out the trends of the behaviours, or triggers, etc. The NM further indicated that once the identified intervention was completed, the information was used by the external agency, to identify the cause of the behaviour, related triggers, and put interventions in place to manage the responsive behaviour.

The Inspector interviewed the ADOC #103, who verified that every staff member who was working on the unit was responsible for documenting the outcome of the intervention. They indicated that it was the expectation that the documentation was recorded as required which assisted the health care team to identify potential triggers that would minimize the risk of the responsive behaviour occurring again. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behavioiurs, the behavioural triggers for the resident are identified; to ensure that strategies are developed and implemented to respond to the resident who demonstrates responsive behaviours, and to ensure that residents response to interventions are documented, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan is no longer necessary.

A CIS report was submitted to the Director regarding incidents of resident to resident abuse that occurred on an identified day, and again, the following day, that both involved resident #002.

A further record review completed by Inspector #647, of the health records, that included the progress notes indicated that resident #002 had one previous physical altercation towards another resident earlier in the same identified month.

A further review of the progress notes for resident #002 for a three month period of time, indicated that they had episodes of a type of behaviour.

A review of the resident’s plan of care had not included the type of behaviour as documented in the progress notes for resident #002.

During staff interviews with PSW's #107 and #110, they both indicated to Inspector #647 that they had cared for resident #002 since their admission. They indicated that the resident had been observed with the behaviour.

Inspector #647 interviewed RN #102 and RPN #108 who indicated they were aware of resident #002’s new behaviour. When reviewing the plan of care for resident #002, they both indicated that the plan of care had not been reviewed or revised when the new behaviour had started.

During an interview with the external agency, they indicated that the plan of care should have been revised to ensure staff were aware of this current risk of resident #002 due to the new behaviour.

During an interview with the DOC, Inspector #647 reviewed resident #002's current care plan for responsive behaviours. The DOC stated they were not aware that the resident had a new behaviour. The DOC agreed that there were gaps in the plan of care related to the risk of resident #002 due to the new behaviour.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.