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_0031	021469-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): December 2 - 6, 2019.

The following intake was completed in this Complaint inspection:

-one intake related to a complaint submitted to the Director regarding medication administration, pain management, employee conduct and unresolved complaints.

Critical Incident System inspection #2019_565647_0032 was conducted concurrently with this Complaint 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), 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:
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints**

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provided direct care to

a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A complaint was submitted to the Director regarding concerns with effective pain management specifically for resident #003.

a) Inspector #692 reviewed the "Diagnosis Report" in Point Click Care (PCC), which identified that resident #003 had two identified diagnosis.

A review of resident #003's health care records, by Inspector #692, identified that their most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS), indicated they had pain. A further review of resident #003's progress notes identified an assessment progress note, that indicated that pain was noted, and that it was ongoing. Inspector #692 reviewed resident #003's written care plan, that was in effect at the time of the inspection, and was unable to locate a focus for pain, or any interventions to direct staff how to manage their pain.

During an interview with Inspector #692, resident #003 indicated that they had exhibited symptoms of pain daily. Resident #003 indicated that they receive specific pain interventions.

b) Inspector #692 reviewed the "Diagnosis Report" in PCC, which identified that resident #007 had one identified diagnosis.

A review of resident #007's health care records, by Inspector #692, identified a pain assessment, which identified that the current pain management program was satisfactory with managing their pain. Inspector #692 reviewed resident #007's written care plan, that was in effect at the time of the inspection, and was unable to locate a focus for pain, or any interventions to direct staff how to manage their pain.

During an interview with Inspector #692, resident #007 indicated that they had occasionally experienced symptoms of pain during specific activities of daily living. Resident #007 indicated that they receive specific pain interventions.

c) Inspector #692 reviewed the "Diagnosis Report" in PCC, which identified that resident #002 had one identified diagnosis.

A review of resident #002's health care records, by Inspector #692, identified a pain

assessment, which indicated that resident #002 was currently exhibiting pain to a specified area. A further review, identified a consultation report from an identified specialist, which indicated that resident #002 had been experiencing pain. Inspector #692 reviewed resident #002's written care plan, that was in effect at the time of the inspection, and was unable to locate a focus for pain, or any interventions to direct staff how to manage their pain.

Resident #002 was not interviewable.

In separate interviews with Personal Support Workers (PSW) #111 and #112, they both indicated to Inspector #692 that they only had access to the residents written care plan and kardex in PCC in order to know what care the residents required, which included what interventions were to be implemented for each resident. Both PSW #111 and #112 indicated that they did not know these residents had pain and would not know what care to provide if the residents written care plan did not include the appropriate information.

During separate interviews with Inspector #692, Registered Practical Nurses (RPN) #108 and #109 indicated that it was the responsibility of the registered staff to ensure that the residents written care plan included information for direct care staff to know what interventions to implement, in order to provide individualized resident care. RPN #109 identified that resident #003 and #007 had exhibited pain, and RPN #108 identified that resident #002 had been exhibiting pain. However, when they reviewed the residents current written care plan, they indicated that it had not included a focus for pain.

In an interview with Registered Nurse (RN) #113, they indicated to Inspector #692 that the resident's written care plan was to include current relevant information regarding their care needs and what interventions were to be implemented in order to manage their care. Together, RN#113 and the Inspector reviewed resident #002, #003 and #007's current written care plan, in which RN #113 identified that they did not have a pain focus or included the interventions to direct staff how to manage their pain, and they should have.

In an interview with Associate Director of Care (ADOC) #116, they indicated to Inspector #692 that direct care staff only had access to the residents care plan and were to reference that in order to know what interventions they were required to implement. ADOC #116 identified that resident #002, #003 and #007's written care plan did not identify that the residents had pain, nor included the appropriate planned care for each resident. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and has convenient and immediate access to it, to be implemented voluntarily.

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.