Ontario

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

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

North District
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Original Public Report

Report Issue Date: November 22, 2023	
Inspection Number: 2023-1454-0003	
Inspection Type: Complaint	
Licensee: Spencer House Inc.	
Long Term Care Home and City: Spencer House, Orillia	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature** Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.12.04 10:14:36 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 8, 9, 10, 2023

The following intake(s) were inspected:

- One intake, which was a complaint related to an allegation of staff to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard issued by the Director with respect to infection

prevention and control (IPAC).

Pursuant to the "Infection Prevention and Control Standard for Long-Term Care Homes" (the Standard) issued by the Director in April 2022, staff were to perform Hand Hygiene (HH) before applying and after removal of Personal Protective Equipment (PPE), and when entering and exiting a resident's environment.

Summary and Rationale
1. A staff member was delivering food and fluids to a resident. There was signage on the door to the resident's room that indicated that there were additional precautions in place. The staff member was observed to apply the required PPE and enter the resident's room without performing any HH. Upon exiting the resident's room, the staff member removed some of the PPE, proceeded down the hall and removed the rest of the PPE, and then performed HH.

2. A personal Support Worker (PSW) was delivering food and fluids to a resident. There was signage on the door to the resident's room that indicated that there were additional precautions in place. The PSW applied the required PPE, however; no hand hygiene was performed during the application of the PPE.

The IPAC Lead and the Director of Care (DOC) confirmed that staff were to perform hand hygiene during the donning and doffing process and prior to entering the resident's room.

The home's failure to ensure that staff performed HH at the appropriate times presented moderate risk to residents due to the possible transmission of pathogens from staff.

Sources: Observations of two staff members; the home's Hand Hygiene policy; interviews with staff, IPAC Lead and the DOC.
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WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection were recorded for three residents.

Rationale and summary

The long-term care home was experiencing a disease outbreak. A document in the home identified the residents that were experiencing symptoms of the infectious disease. After a review of three of the affected resident's health records, it was identified that there were a number of shifts in which there was no record of symptom monitoring found for all three residents.

A registered Practical Nurse (RPN) stated that residents that had symptoms of infection were monitored frequently throughout each shift; however, they were unsure of which assessments on Point Click Care (PCC) to complete, and how often to document on the residents. Another RPN confirmed that all residents with symptoms of infection were to be assessed and the assessment documented in PCC on every shift. The DOC verified that there was no record of symptom monitoring on every shift for all residents that were presenting with symptoms of infection.

The home’s failure to ensure that symptoms indicating the presence of infection was recorded on every shift presented a moderate risk to the residents as the residents involved had been diagnosed with the infectious disease at the time.

Sources: The home’s outbreak investigation line list form; three resident’s progress notes and assessments on PCC; interviews with Registered staff, IPAC Lead and the DOC.
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