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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 21, 2023.
Inspection Number: 2023-1454-0004
Inspection Type: Complaint Critical Incident
Licensee: Spencer House Inc.
Long Term Care Home and City: Spencer House, Orillia

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2023.12.29 08:39:21 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-30, and December 1, 4-5, 2023.

The following intake(s) were inspected:

- two intakes related to Critical Incident Reports received by the Director regarding allegations of resident to resident abuse; and,
- one intake related to a complaint received by the Director regarding an allegation of resident to resident abuse.

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

Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care not Provided as per Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

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

Rationale and Summary
The resident's care plan indicated that the resident was to have a specific intervention in place to assist in managing responsive behaviours.

Upon observation it was noted that the intervention was not in place.

The Registered Practical Nurse (RPN) indicated that while they were aware of the intervention, they were unsure if it was actually being implemented.

Sources: Inspector observations; resident's care plan; interview with the RPN, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Plan of Care not Revised

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that when the resident's care needs changed, the plan of care was reviewed and revised.

Rationale and Summary
Progress notes indicated that the resident required the use of an assistive device for ambulation.

The resident's care plan and Kardex did not indicate the use of assistive devices.

The RPN confirmed that the resident utilized an assistive device for ambulation.

The Associate Director of Care (ADOC) indicated that the resident's care plan should have been updated to reflect any assistive devices the resident was utilizing.

Sources: The resident's progress notes and care plan; interviews with the RPN, Personal Support Worker (PSW), and ADOC.

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WRITTEN NOTIFICATION: Immediate Investigation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone.

The licensee has failed to ensure that the allegation of resident to resident abuse involving two residents was immediately investigated.

Rationale and Summary
The RN informed the manager on call of a potential resident to resident abuse situation, when the situation took place. The RN indicated that the staff took no immediate action to investigate what had happened between the two residents.

The ADOC indicated that the investigation into the allegation of abuse did not begin immediately.

There was actual risk of harm to residents, as a result of the investigation not beginning immediately, as the home was unaware of what had taken place.

Sources: CI; internal investigation notes; and, interview with the ADOC, DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Strategies to Manage Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that when the resident demonstrated behaviours, that strategies and interventions were developed and implemented.

Rationale and Summary
The resident was known by staff to display responsive behaviours, that posed minimal risk to other residents.

A review of the resident's plan of care did not identify the known behaviour, and there were no strategies or interventions developed to assist in managing the behaviour.

The ADOC indicated that the resident was known to exhibit the behaviour and confirmed that the plan of care did not indicate strategies or interventions to assist staff in managing the resident's behaviour.

Sources: The resident's progress notes and care plan; interviews with the ADOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Preventing Resident to Resident Altercations

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60 (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The licensee has failed to ensure that procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary
The resident was known to display responsive behaviours, and progress notes indicated that on various occasions in a three month period, the resident had displayed responsive behaviours.

The DOC identified that there were gaps in the home's process for identifying factors that may trigger a resident's responsive behaviours and gaps in developing interventions to mitigate the risks to other residents.

There was actual risk of harm to residents by the home not having procedures in place to minimize the risk of altercations between residents.

Sources: Progress notes and care plans for three residents; and, interviews with the RPN, DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Police Notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the police were immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary
There was a resident to resident altercation, however, the DOC indicated that police were not notified of the incident until two days after the incident took place.

There was risk to residents by the appropriate police force not being immediately notified of a situation that may have constituted a criminal offence.

Sources: The resident's progress notes; internal investigation documents, including police warrants; and, interview with the DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Record of Complaint

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a written record was kept of a complaint received regarding an incident involving the resident.

Rationale and Summary
The DOC acknowledged a complaint that had been sent, however, the DOC indicated that the home had kept no written record of the complaint, or the actions the home took to resolve the complaint.

Sources: internal email communications; complaints binder; licensee's policy titled "Complaints Management Policy", XXIII-E-10.00, last revised June 2023; and, interview with the DOC, and other relevant staff.

[736]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- review the policy titled "Prevention of Abuse and Neglect of a Resident", with specified staff members, highlighting the requirements set out related to the investigation of allegation of resident abuse. Record is to be kept of the education, the names of those who participated, the date of the education, and who provided the education;
- develop a process and strategies within the home to manage resident to resident altercations, including minimizing the risk of potentially harmful interactions between resident, and ensuring that all staff are aware of potentially harmful interactions between residents;
- develop an internal process to ensure that appropriate staff members are notified when a resident demonstrates responsive behaviours so that appropriate interventions can be implemented.;
- conduct audits for a period of four weeks to ensure that residents who display escalating behaviours have the appropriate staff notified; and,
- develop an internal process so that staff who are assigned to provide a specified type of care to a resident with responsive behaviours are aware of the behaviours exhibited, any relevant triggers, and interventions that are in place for that resident.

Grounds

The licensee has failed to protect residents from abuse.

Rationale and Summary

1. Altercations occurred between two residents. Following the altercations, not all of the required staff members were promptly notified and there were gaps in the required monitoring that was implemented. Interventions were also not immediately put into place to manage one of the resident's responsive behaviours.

During the inspection, one of the resident was to have a specific intervention in place, however, the Inspector observed the resident without the intervention in place.

The specified intervention also intervention did not meet the needs and routines of the resident.

2. There were two documented interactions between residents, however, no further interventions or strategies were put into place in attempts to prevent resident to resident interactions. The required staff members were also not notified of the interactions.

The ED indicated that based on the lack of actions taken by the home to prevent altercations between residents, the home did not take steps to protect residents from abuse from the resident.

There was actual harm caused to a resident when the home did not take steps to protect residents from abuse.

Sources: A resident's progress notes and care plan, physicians orders, additional assessments; progress notes two residents; internal investigation notes; interviews with the RN, ADOC, Physician, DOC, ED, and other relevant staff.

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This order must be complied with by February 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.