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

Public Report

Report Issue Date: June 19, 2025
Inspection Number: 2025-1454-0002
Inspection Type: Critical Incident
Licensee: Spencer House Inc.
Long Term Care Home and City: Spencer House, Orillia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16-19, 2025

The following intake(s) were inspected:

- Two intakes, related to infectious disease outbreaks; and,
- One Intake, related to a fall of a resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for

strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's falls prevention and management program, which indicated that direct care staff were to implement fall prevention interventions that were identified in the resident's plan of care.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program, and ensure they were complied with.

Specifically, staff had not complied with the home's policy when a resident had sustained a fall, and was found without the specific interventions implemented. The resident's plan of care indicated that they were to have specific fall prevention interventions in place at all time, due to being a risk for falls.

Sources: Critical Incident (CI) report; a resident's health care records; the home's policy titled, "Falls Prevention and Management"; and interviews with direct care and registered staff, and the Director of Care (DOC).

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