Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 15, 16, 17, 18, 22, 23, 24, 25, 28, Jun 5, 6, 2012	2012_078202_0013	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 INC.
835 West Ridge Blvd., ORILLIA, ON, L3V-8B3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VALERIE JOHNSTON (202), JANE CARRUTHERS (113)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Food Service Manager, Environmental Service Manager, Resident Relations Coordinator, Registered Nurses, Personal Support Worker, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, observed meal service, conducted a walk through of all resident home areas, reviewed clinical records, pest control records, call bell records, maintenance communication books, Resident Food Advisory Committee minutes, Resident Council minutes, home's policies related to Terms of Reference for Food Advisory Committee, Responsive Behaviours Management, Personal Care, Restraint Physical and PASD

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Dining Observation

Infection Prevention and Control

Minimizing of Restraining

Personal Support Services

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. Staff on the secure unit, Willow Lane, did not respond to a door alarm that sounded at the entrance into the unit. On May 16, 2012 at approximately 2:00pm the door alarm went off and staff on the unit did not come to investigate the cause. As a result of the continuation of the door alarm, the charge nurse received a communication on her pager and also did not respond.

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 home is a safe and secure environment for its residents. This plan is, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective. [s.6.10 (c)]

Resident A's written plan of care identifies this resident as physically abusive, socially inappropriate and resistive to care. Progress notes and annual care conference notes reviewed for May 2011-May 2012, revealed that resident A was physically abusive to staff on May 21, July 20, August 08, Septeber 09, October 14, October 23, 2011 and January 09, February 13, April 02, 04, 2012. Staff interviews revealed that the written strategies for resident A have not been effective was not reassessed. [s.6. 10 (c)]

Resident B's written plan of care identifies this resident as wandering and will rummage in other resident rooms. Clinical record review and staff interview revealed that the written strategies for resident resident B have not been effective was not reassessed. [s.6.(10)(c]
2. The licensee failed to ensure that the care set out in the plan of care provides clear directions to staff and others who provide care.[s.6.(1)(c)]

Clinical record review states that resident resident C has a safety device/restraint put in place for the safety of this resident and those around this resident. The written plan of care for resident C does not provide any directions to staff for use of the safety device/restraint and what the device is used for.[s.6.(1)(c)]

Clinical record review revealed that resident's A,B,and C, are to be monitored by staff hourly for use of a 'tilt'. The written plan of care for resident's A,B,and C provide no direction to staff and others who provide care for the actual use of the 'tilt'. Staff interview confirmed that the use of the 'tilt' for resident's A,B and C was unclear.[s.6.(1)(c)]
3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6.(7)]

Resident E's written plan of care directs staff to provide a bath on Tuesday and Saturday evening. Clinical record review for resident E March 2012-May 2012 revealed that baths were not provided on March 03, March 31, April 07, May 5, May 12, 2012. Staff interview confirmed that baths are often not provided when they are short staffed.[s.6.(7)]

Resident F's written plan of care directs staff to provide a bath on Tuesday and Friday AM. Clinical record review for resident F March 2012-May 2012 revealed that baths were not provided on March 31, April 07 and May 05, 2012. Staff interview confirmed that baths are often not provided when they are short staffed.[s.6.(7)]

Resident G's written plan of care directs staff to provide a bath on Wednesday and Saturday PM. Clinical record review revealed that resident G did not receive a bath on March 13, April 7 and May 05, 2012. Staff interview confirmed that on days when staff are busy resident baths are often missed.[s.6.(7)]

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 written plan of care sets out clear directions to staff and that the care set out in the plan of care is provided to the resident and is reassessed when not effective. This plan is, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The cleaning schedule for resident A's wheelchair indicated that it was to be cleaned twice a week. Records show that it was cleaned every 7 to 8 days.
On May 15, 2012, resident A's wheelchair was heavily soiled on the seat and the frame of wheelchair.[s.15.(2)(a)]
2. The Arjo tub on Willow Lane was not maintained in a safe condition and in a good state of repair. It was documented in the maintenance communication book on February 3, 2012 and again on March 16, 2012 that a hose on the Arjo tub had split and was leaking on the tub room floor.
Staff interviews confirmed that the tub remained in use during this time, and was not repaired until April 9, 2012.[s.15.(2)(c)]

Walls in Willow Lane are not in a good state of repair as wall paper is loose and ripped in hallways and walls require patching and repainting in resident rooms.
There is a broken handle on a chest of drawers in the lounge on Willow Lane and a broken plate on the electrical socket in room 105.[s.15.(2)(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 the home, furnishings and equipment are kept clean and sanitary and maintained in a safe condition and in a good state of repair. This plan is, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.[s.71.(4)].

Resident and staff interviews indicate that the planned menu items are not always available at each meal and snacks for residents. [s.71.(4)]

Dietary staff confirmed that they frequently run short of texture modified food. As a result, residents on textured modified diets do not consistently receive a full meal according to the planned menu. Dietary staff revealed that they are repeatedly short potatoes when couscous is offered.

Resident interviews revealed that there are often shortages of one particular food item at lunch or dinner and the shortage is often potatoes or dessert.[s.71.(4)]

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 planned menu items are offered and available at each meal and snack. This plan is, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are bathed, at a minimum, twice a week by the method of his or her choice. [s.33.(1)]

Resident A's written plan of care directs staff to provide a bath on Monday and Thursday. Clinical record review for resident A January 2012-May 2012 revealed that baths were not provided on January 26, February 16, March 15,March 19, April 12, 2012. Staff interview confirmed that baths are often missed when there are staffing issues.[s.33.(1)]

Resident B's written plan of care directs staff to provide a bath on Tuesday and Friday AM. Clinical record review for resident B March 2012-May 2012 revealed that baths were not provided on March 31, April 07 and May 05, 2012. Staff interview confirmed that baths were not provided due to staffing issues.[s.33.(1)]

Resident C's written plan of care directs staff to provide a bath on Wednesday and Saturday PM. Clinical record review for resident C March 2012-May 2012 revealed that baths were not provided on March 13, April 07 and May 05, 2012. Staff interview confirmed that baths were not provided due to staffing issues.[s.33.(1)]

Resident D's written plan of care directs staff to provide a bath on Tuesday and Saturday evening. Clinical record review for resident D March 2012-May 2012 revealed that baths were not provided on March 03, March 31, April 07, May 5, May 12, 2012. Staff interview confirmed that baths are often not provided when they are short staffed.[s.33.(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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice. This plan is, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. On May 18, 2012 a dietary worker in the servery in Willow Lane used the same gloves while multitasking using the telephone and working with food.
2. On May 18, 2012 an unlabeled and used brush and comb which were left in the tub room on Willow Lane. Plastic spoons on the med cart on Willow Lane were stored improperly. 6 unlabeled nail clippers were left together in a plastic container in the tub room on Maple Lane.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to provide annual training in behaviour management to direct care staff pursuant to section O.Reg 79/10 s. 221 (2)1.

Interviews were conducted with direct care staff throughout the home. Direct care staff assigned to the secure unit revealed through interview that behaviour management training had not been provided to them in the home and they were not aware of a responsive behaviour program in the home.

Educational record review for 2011 confirmed that all direct care staff assigned to the secure unit of the home had not been provided training in techniques and approaches related to responsive behaviours.[s.76.(7)3]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care for resident B includes consent by the Substitute Decision Maker (SDM).[s.31.(2)5]

Clinical record review revealed that resident B was prescribed a temporary restraint seat belt on January 24, 2012 by her physician. Staff interview and clinical record review conducted on May 17, 2012 confirmed that resident B did not have consent for restraint by the SDM and continues to use the restraint.[s.31.(2)5]

Issued on this 22nd day of June, 2012

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