



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2014	2014_281542_0024	S-000552-14, S-000461 -14, S-000525-14, S- 000541-14	Complaint

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East Box 9600 Sault Ste Marie ON P6A 7C1

Long-Term Care Home/Foyer de soins de longue durée

F. J. DAVEY HOME
733 Third Line East Sault Ste Marie ON P6A 7C1

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

JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 1, 2, 3, 4, 2014

**Ministry of Health Logs Inspected: 008461-14/S-000552-14, 006190-14/S-000461-14,
007885-14/S-000525-14, 008372-14/S-000541-14**

During the course of the inspection, the inspector(s) spoke with the Executive Director (Acting), Executive Director of Nursing, Director of Nursing, Registered Staff, Personal Support Workers (PSWs), Dietary Supervisor, Dietary Aides and Residents.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Pain

Personal Support Services

Reporting and Complaints

Responsive Behaviours

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

3 WN(s)

1 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :



1. On December 1, 2014 Inspector # 542 completed health record reviews for resident # 001 & # 002. Resident # 001's most current RAI-MDS assessment indicated that they required total assistance by 1 staff member for eating. The RAI-MDS also indicated that resident # 001 had severely impaired decision making skills and was rarely or never understood by others. Inspector # 542 reviewed resident # 001's nutritional intake record and noted that over a one month period it had been documented that the resident refused breakfast 22/30 times. Resident # 002's most current RAI-MDS assessment indicated that they required total assistance by 1 staff for eating and is at moderate nutritional risk. The RAI-MDS also indicated that resident # 002 had severely impaired decision making skills and was sometimes understood by staff. Inspector # 542 reviewed resident # 002's nutritional intake record and noted that it was documented that the resident refused breakfast 14/30 over a one month period.

On December 2, 2014 Inspector # 542 observed from 0810 hr until 1045 hr on the unit where both resident # 001 and # 002 reside. It was noted by this Inspector that both of the mentioned residents were in bed for the duration of the observation. Inspector # 542 noted that staff members did not offer resident # 001 and resident # 002 any breakfast. Inspector # 542 also noted that 1 breakfast tray was delivered to a resident residing in a different wing of this home area. Inspector verified this with the Dietary Aide working on this particular home area. Inspector # 542 interviewed the Registered Practical Nurse (RPN) who stated that the residents were not offered breakfast and that the staff didn't have time to go back and feed these residents but the staff should have offered a "continental breakfast" to the residents that were still in bed. Inspector met with the the Executive Director (Acting) overseeing the home and informed her of the above incident. The Executive Director stated that this warrants abuse/neglect and that she would follow up with this incident.

The licensee failed to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device



Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. On December 2, 2014 the Inspector observed resident # 002 to be resting in bed with two bed rails raised. Inspector # 542 reviewed the resident's health care record and noted that the resident's care plan did not identify the use of a restraint related to the bed rails. Inspector # 542 then reviewed the doctor's orders and noted that there was an order to discontinue the use of the bed rails. Inspector # 542 spoke with the RPN who verified that the resident was not to have the bed rails raised as there was no further doctor's order for the use of the bed rail restraints.

The licensee failed to ensure that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 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 staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class for resident # 002, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. On December 2, 2014 Inspector # 542 observed from 0810 hr until 1045 hr on the unit where both resident # 001 and # 002 reside. It was noted by this Inspector that both of the mentioned residents were in bed during the duration of the observation. Inspector # 542 noted that no staff members offered resident # 001 and resident # 002 any breakfast. Inspector # 542 also noted that 1 breakfast tray being delivered to a resident residing in a different wing of this home area. Inspector verified this with the Dietary Aide working on this particular home area. Inspector # 542 interviewed the RPN who stated that the residents were not offered breakfast and that the staff didn't have time to go back and feed these residents but they should have received a "continental breakfast." Inspector met with the home's administrator overseeing the home and informed her of the above incident. The Executive Director (Acting) stated that this warrants abuse/neglect and that she would follow up with this incident. Inspector # 542 noted that this incident was not reported to the Director.

The licensee failed to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director. [s. 24. (1) 2.]



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Issued on this 5th day of January, 2015

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

Original report signed by the inspector.



**Ministry of Health and
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : JENNIFER LAURICELLA (542)

Inspection No. /

No de l'inspection : 2014_281542_0024

Log No. /

Registre no: S-000552-14, S-000461-14, S-000525-14, S-000541-14

Type of Inspection /

Genre

d'inspection:

Complaint

Report Date(s) /

Date(s) du Rapport : Dec 30, 2014

Licensee /

Titulaire de permis :

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON,
P6A-7C1

LTC Home /

Foyer de SLD :

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s)
by the date(s) set out below:



**Ministry of Health and
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**Ministère de la Santé et
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s. 19 (1) and prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff through failure to offer residents three meals daily. The plan shall include specified time frames for the development and implementation and identify staff member (s) responsible for the implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by January 19, 2014.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

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The licensee failed to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff. (542)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jan 19, 2015



**Ministry of Health and
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of December, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Jennifer Lauricella

Service Area Office /

Bureau régional de services : Sudbury Service Area Office