Ontario

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 30, 2015	2015_281542_0014	12430-15, 12441-15, 12435-15, 12440-15, 12439-15, 20409-15, 12438-15	Follow up

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 6, 7, 10, 11 and 12, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Nursing, Director of Nurse (s), Registered Staff, Personal Support Workers, Residents and Family Members

During the inspection, the Inspector conducted a walk through of resident home areas, observed staff to resident interactions, reviewed health care records, employee files and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (2)	CO #004	2015_281542_0002	542
O.Reg 79/10 s. 131. (2)	CO #002	2015_281542_0002	542
O.Reg 79/10 s. 17. (1)	CO #003	2014_304133_0008	542
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_281542_0008	542
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #003	2015_281542_0002	542

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. 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. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #542 reviewed a Critical Incident (CI) that was submitted to the Director. The CI indicated that an incident of alleged staff to resident abuse occurred. Furthermore, the CI revealed that S#100 had been seen placing their hand across resident #005's chest stopping them from going out the door. During the same shift, S#100 was overheard raising their voice at resident #008 and was informed by a family member not speak to resident #008 that way. Inspector #542 reviewed the employee file for S#100 which revealed that the home provided S#100 with a written warning for their actions towards resident #005 and resident #008.

Inspector #542 reviewed another CI that was submitted to the Director, which indicated that the same staff member (S#100) was alleged to have been abusive towards resident #006. The CI revealed that S#100 was seen by another employee being forceful with resident #008. It was also witnessed that the resident told S#100 not to be so rough. S#100 was employed by the home after they had received discipline for being abusive with residents. The home did not protect residents from abuse as S#100 continued to be abusive towards residents.

Inspector #542 reviewed another Critical Incident (CI) that was submitted to the Director. The CI indicated that staff #101 was neglectful towards resident #007. The CI indicated that S#101 failed to provide care to resident #007 during their shift and left the resident in a soiled incontinent product until the oncoming shift. [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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

On August 6, 2015, Inspector #542 observed resident #009 in their bed with the call bell located on the floor and not within their reach. Inspector #542 spoke with S#105 who stated that the resident does not use the call bell as they might put it in their mouth. S#105 stated that they were made aware of this the previous day but that they doubted that this information was placed in the resident's plan of care. Inspector asked this staff member how the other staff would know about this specific intervention, the PSW staff responded with "word of mouth." Inspector spoke with S#106 who indicated that they were not aware that the resident was not to have access to their call bell. The most recent care plan accessible to the direct care staff did not indicate that the resident was not to have access to their call bell.

On August 10, 2015, Inspector #542 reviewed the "HCA Charting Record" over a two week period and noted that the PSW's had documented that the resident's call bell was checked and that it was accessible to the resident on all three shifts. Inspector #542 spoke with S#107 and S#108 who both verified that the resident was to have access to their call bell and that the resident did not have any safety risks associated with the use of the call bell.

On August 11, 2015, at approximately 8:18 am, Inspector #542 observed resident #011 in their bed without access to their call bell. The call bell was observed to be hanging off of the wall, out of the resident's reach. Inspector spoke with staff #109 who confirmed that the resident was to have access to their call bell while in bed. Inspector #542 reviewed the "HCA Charting Record" which indicated that resident #011 had access to their call bell during the night shift and that the call bell was checked based on the documentation. The most recent care plan accessible to the direct care team did not indicate if the resident had any specific interventions related to the use of their call bell.

Inspector #542 observed resident #010 in their room, in their wheel chair. The call bell was located on the floor behind the resident, not allowing the resident access to it. S#110 and S#111 stated that resident #010 is to have access to their call bell at all times. The most recent care plan accessible to the direct care team was reviewed by this inspector and noted that there was no mention of whether the resident was to have access to their call bell or not. [s. 17. (1) (a)]

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 resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

Issued on this 7th day of October, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 :	2015_281542_0014
Log No. / Registre no:	12430-15, 12441-15, 12435-15, 12440-15, 12439-15, 20409-15, 12438-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 30, 2015
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 :	Barbara Harten

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_281542_0002, CO #005;

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 ensure that all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. Two previous Compliance Orders were issued under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) in December 2014 during inspection #2014_281542_0024 and in January 2015 during inspection # 2015_281542_0002.

Inspector #542 reviewed a Critical Incident (CI) that was submitted to the Director. The CI indicated that an incident of alleged staff to resident abuse occurred. Furthermore, the CI revealed that S#100 had been seen placing their hand across resident #005's chest stopping them from going out the door. During the same shift, S#100 was overheard raising their voice at resident #008 and was informed by a family member not speak to resident #008 that way. Inspector #542 reviewed the employee file for S#100 which revealed that the home provided S#100 with a written warning for their actions towards resident #005 and resident #008.

Inspector #542 reviewed another CI that was submitted to the Director, which indicated that the same staff member (S#100) was alleged to have been abusive towards resident #006. The CI revealed that S#100 was seen by another employee being forceful with resident #008. It was also witnessed that the resident told S#100 not to be so rough. S#100 was employed by the home after they had received discipline for being abusive with residents. The home did not protect residents from abuse as S#100 continued to be abusive towards residents.

Inspector #542 reviewed another Critical Incident (CI) that was submitted to the Director. The CI indicated that staff #101 was neglectful towards resident #007. The CI indicated that S#101 failed to provide care to resident #007 during their shift and left the resident in a soiled incontinent product until the oncoming shift. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 2015

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

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.

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, 11e 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.

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 September, 2015

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