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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Apr 28, 2017	2017_509617_0006	030561-16, 030933-16, 030935-16, 031523-16, 031569-16, 032634-16, 032987-16, 035202-16, 002627-17, 003132-17, 005085-17, 005769-17	Critical Incident System

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

SHEILA CLARK (617), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 13, 14, 15, 16, 17, 2017

The following Critical Incident System (CIS) reports submitted by the home were inspected:

- five CIS reports related to staff to resident abuse,
- four CIS reports related to resident to resident abuse,
- one CIS report related to a resident fall,
- one CIS report related to a family complaint of resident care provision, and
- one CIS report related to medication administration error requiring transfer to hospital.

A concurrent Complaint Inspection #2017_463616_0003 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care (EDOC), Director of Care (DOC), Staff Education Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the Inspector directly observed the delivery of care and services to residents, resident to resident and staff to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, and personnel files, various home policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was reassessed and their plan of care reviewed and revised when the resident's care needs changed related to their method of bathing.

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff to resident neglect. The CIS report indicated that PSW #111 attempted to provide resident #004 with an incorrect method of bathing which caused discomfort for the resident and was not identified to be used in their care plan.

Resident #004's health care records in effect at the time of the incident were reviewed by the Inspector which indicated they had limited mobility and required staff assistance with bathing. Resident #004's care plan for bathing, indicated resident #004 was to receive a specific type of bath.

In an interview with resident #004 they reported to the Inspector that the staff stopped using the specific type of bath and started using a different type of bathing method on many occasions prior to the critical incident that was reported. Resident #004 explained to the Inspector that this different type of bathing method caused discomfort and was not their preference for bathing.

In an interview with PSW #123 they confirmed to the Inspector that resident #004 did not like using the different type of bathing method because it caused them discomfort. PSW #123 further explained that prior to the critical incident that was reported, staff were providing resident #004 with this different type of bathing method for safety. During the same interview with PSW #123 they reported to the Inspector that the care plan was not revised to indicate this change in the resident's care need.

A review of the home's investigation notes indicated that RPN #112 was disciplined for not revising resident #004's care plan as needed in relation to the CIS report.

An interview was conducted with Director of Care (DOC) #102 on March 15, 2017. They confirmed that resident #004's care needs had changed. Staff were using a different type of bathing method for safety and only after the incident occurred was the care plan re-assessed to indicate that the different type of bathing method was not to be used. The care plan was updated to reflect the resident's changed care needs. [s. 6. (10) (b)]

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 resident #004 is reassessed and their plan of care reviewed and revised when, the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of their investigation and every action taken.

A Critical Incident System (CIS) Report was submitted to the Director in October 2016, which identified an allegation of physical abuse from PSW #109 to resident #002. A review of the CIS report by the Inspector indicated that on a specific date, RN #110 observed PSW #109 assist resident #002 with their mobility in a way that caused an injury to the resident and damage to the environment.

Inspector #617 reviewed the home's investigation notes into the allegation of resident #002 being physically abused by PSW #109 which identified that physical abuse did occur.

During an interview on March 16, 2017, with the Inspector, Executive Director of Care (EDOC) #100 confirmed that the result of the home's investigation did conclude that resident #002 sustained injury from the incident and they were physically abused by PSW #109.

A review of the CIS report amended on a specific date included the home's actions taken as a result of the incident but did not include the results of the home's investigation.

A review of the home's policy titled "Jurisdictional Reporting Requirements - #RC-02-01-02 A1" revised on April 2016, indicated that results of an abuse investigation and any actions taken to the incident must be submitted by management using the Critical Incident System.

During an interview on March 16, 2017, with the Inspector, EDOC #100 confirmed that the CIS report had not been amended to indicate the results of the home's investigation. [s. 23. (2)]

2. A CIS report was submitted to the Director in October 2016, which identified that an incident of alleged neglect occurred toward resident #001 by PSW #106 and PSW #107. The CIS report indicated that on a specific date resident #001's family member approached RPN #108 and accused the staff of neglecting the resident's care.

A review of the home's investigation notes into the allegation of neglect for resident #001 identified that neglect did not occur and the home managed the CIS report as a family complaint.

During an interview on March 16, 2017, with the Inspector, DOC #102 confirmed that the result of the home's investigation did conclude that the alleged neglect of resident #001 was unfounded.

A review of the CIS report amended on a specific date included the actions taken as a result of the incident but did not include the results of the home's investigation.

During an interview on March 16, 2017, with the Inspector, DOC #102 confirmed that the CIS report had not been amended to indicate the results of the home's investigation [s. 23. (2)]

3. The home submitted a CIS report regarding staff to resident emotional abuse. A review of the CIS report indicated that in January 2017, PSW #113 found resident #005 visibly upset. Resident #005 explained to PSW #113 that the way they were treated by PSW #114 during care provision caused them to be emotionally upset.

A review of the home's investigation notes into the allegation of resident #005 being

emotionally abused by PSW #114 identified that emotional abuse did not occur.

During an interview with the Inspector on March 15, 2017, EDOC #100 confirmed that the results of home's investigation into the allegation of emotional abuse toward resident #005 from PSW #114 was unfounded. They reported that the home concluded their investigation one day after the critical incident was reported.

A review of the home's initial CIS report had not been amended by the home. The initial CIS report did include the home's actions taken as a result of the incident but did not include the results of the home's investigation.

During an interview on March 15, 2017, with the Inspector, EDOC #100 confirmed that the CIS report had not been amended to indicate the results of the home's investigation. [s. 23. (2)]

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 results of every investigation undertaken under clause (1) (a) is reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A CIS report was submitted by the home to the Director in March 2017, related to a

medication administration incident that occurred that on a particular day. In the report, RPN #105 had administered a co-resident's medications to resident #016 in error. The report indicated that after being administered the co-resident's medication, resident #016's health status was compromised for which they were transferred to hospital for assessment and observation.

A review of the home’s investigation and internal incident report was conducted by Inspector #617. At the time of the administration RPN #105 was unfamiliar with resident #016, and used only their picture on the electronic Medication Administration System (eMAR) to identify the resident. Resident #016 was not wearing their name band on their wrist at the time of the administration. As a result of the staff’s incorrect identification of resident #016, nine medications were administered to the resident in error.

A review of resident #016’s Medication Administration Record (MAR) in effect at the time of the incident was completed by the Inspector. The medications ordered for this resident did not include the nine medications that were administered in error.

In the home's pharmacy policy and procedure manual a policy titled "The Medication Pass-#3-6: updated on January 2014, in effect at the time of the incident, indicated that Registered staff were to ensure that each resident received the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The registered staff were to identify the resident using two identifiers, such as photo, armband or other staff, never by verbal response.

In an interview with RPN #124 they reported to the Inspector that it was the policy of the home and a standard of practice to perform a two identifier check to ensure the right resident received the correct medication. RPN #124 further explained that if they were not familiar with the residents they would use the resident’s picture on the eMAR, arm band and/or ask staff who were familiar with the resident to identify them to the registered staff.

During an interview with the Inspector on March 17, 2017, DOC #102 confirmed that resident #016 should not have received medications that were not prescribed to them and that RPN #105 did not use two identifiers to ensure the right resident received the correct medication. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident, to be implemented voluntarily.

Issued on this 28th day of April, 2017

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

Original report signed by the inspector.