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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018	2018_671684_0007	002664-18	Resident Quality Inspection

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East 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

SHELLEY MURPHY (684), JENNIFER LAURICELLA (542), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 20-23, 2018, and February 26-March 2, 2018.

Additional intakes inspected during this Resident Quality Inspection (RQI) included:

Two complaints #023682-17 and #026546-17, related to infection control, resident rights, and plan of care;

One complaint #000161-18, related to falls, infections, plan of care and medication administration;

One complaint #003191-18, related to denied admission, and;

One complaint #003831-18 related to choking.

Six critical incidents, #020616-17/2936-000037-17, #025854-17/2936-000043-17, #027022-17/2936-000045-17, #002904-18/2936-000006-18, #003945-18/2936-000008-18, and #00406618/2936-000009-18 related to falls.

The Inspector(s) also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care, Director of Care (DOCs), Infection Control Lead, Admission Coordinator, Assistant Director of Environmental Services, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **4 WN(s)**
- **1 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #613 reviewed a critical incident (CI) report that was submitted to the Director on a day in 2017, identifying that resident #021 had a fall, resulting in injuries. The CI report revealed that PSW #118 witnessed resident #021 stand up, in a specified location, lose their balance and fall. The CI report identified that a specified intervention was to be used; said intervention was not utilized for resident #021.

A review of the care plan by Inspector #613 identified that resident #021 had a specified intervention to inform staff if the resident tried to complete a certain task. The care plan also indicated that resident #021 often attempted to complete a certain task from a specified position, as well, a second intervention was not utilized, and resident #021 was to be monitored for safety.

During an interview with PSW #118, they stated to Inspector #613 that they had witnessed resident #021 fall in a certain location. PSW #118 revealed that the resident's two interventions that were to be used while they were positioned in a specific way, were not utilized. PSW #118 stated that PSW#124 had been responsible for resident #021.

During an interview with RPN #114, they confirmed that resident #021's specified interventions while positioned in a specific way were not utilized as per care plan at the time of the fall. RPN #114 further stated that the PSWs were to check that the specified interventions were being utilized and operating properly for resident #021 at the start of their shift and that the interventions should always be utilized when the resident was positioned in a specific way in a certain location. The RPN stated they had spoken to PSW #124 to remind them to complete safety interventions as the resident was at risk for falls.

During an interview with Director of Care #120, they confirmed that PSW #124 had not followed resident #021's care plan. DOC #120 further stated that PSW #124 was responsible to check resident #021's interventions to ensure that they were working, and to ensure that the specified intervention were utilized when they brought resident #021 a specific location.

As resident #021's two specific care plan interventions were not utilized, the licensee failed to ensure that the care set out in the plan of care was provided as specified in the plan of care. [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 care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident could communicate in confidence, receive visitors of his or her own choice and consult in private without interference.

A complaint was submitted to the Director related to specified visits on a day in 2017. The complaint indicated that the certain individuals were unable to meet with the resident privately.

Inspector #684 reviewed a letter from a contract provider from a specified date in 2017. One portion of the letter stated the following: "The Presence of Security- We would like to highlight the fact that security has been advised to remain within "ear shot" of anyone visiting with the resident. Typically, the security guard will remain outside of the Resident's room, but the door to the room must remain fully open".

A review of a notice to the contract provider by Inspector #684 stated the following: "remain outside of the Resident's room but keep the door to the room fully open".

The Inspector reviewed the Resident and Family Handbook last revised July 13, 2017, which indicated Residents' Bill of Rights, #21- "Every Resident has the right to meet privately with his or her spouse or another person in a room that assures privacy", another document within the Handbook was Commitment to Residents, #7- "Has privacy when receiving counseling, treatment or personal care, or when communicating with family, friends, lawyers, clergy, government representatives or any other person".

During an interview with Inspector #684 regarding visitors for resident #018 the Administrator stated they were not concerned about resident safety. In a further interview with the Administrator, Inspector #684 asked, does the facility promote the resident's right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference. Administrator confirmed "yes we do and we promote that".

The licensee failed to ensure that resident #018's right to meet privately was maintained, and the Residents' Bill of Rights was complied with, as the resident was precluded from meeting privately with specific individuals. [s. 3. (1) 14.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee withheld the approval; (b) a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justified the decision to withhold approval; and (d) contact information for the Director.

A complaint was submitted to the Director indicating that the licensee denied an applicant 's admission to the home.

During an interview with Inspector #542, the Admission's Coordinator for the home provided the Inspector a document that verified that the home received the application for admission, and denied the admission one week later. They indicated that they were not aware that they were required to provide a written notice to the applicant, the Director and the appropriate placement coordinator setting out the reasons for withholding approval for admission. The home's Admission Coordinator verified that they did not provide a written notice to anyone.

The application for admission process was not followed whereby the licensee was to provide a written notice to the applicant, the Director and the appropriate placement coordinator setting out the reasons for withholding approval for admission. [s. 44. (9)]

WN #4: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that documentation included every release of the device and all repositioning of the resident.

A complaint was submitted to the Director indicating that resident #018 did not have their safety mobility aid applied as required to ensure resident safety.

Inspector #684 reviewed the Resident Record for resident #018 for a specific period of time, and noted there was missing documentation for a specific number of shifts.

Inspector #684 reviewed resident #018 care plan which indicated; PSW assigned to resident #018 was to perform checks to ensure proper interventions were being applied and document on this in the resident chart.

Inspector #684 reviewed the home's policy titled Physical Restraints, # RESI-10-01-01, dated November 2012, Inspector #684 noted the following: Care staff- Ensure the Restraint Record is completed. Monitoring of restraint use must be completed with hourly safety checks and two hourly position changes which requires the release of the restraint and documentation on the restraint record or in e-documentation (i.e. Point of Care (POC) tablet task).

Inspector #684 interviewed PSW #122 regarding specific documentation related to this resident care area. They stated that the documentation was to be completed as specified in the care plan.

Inspector #684 interviewed RPN #123 who indicated that the Registered staff signed the documentation record to indicate the intervention was still required, and the PSWs signed the documentation record to show that they had implemented the intervention appropriately for the resident. Inspector #684 asked RPN #123 specifically about the specific shifts, where there was no documentation; RPN #123 stated they must have forgotten to document on resident #018.

During an interview with Inspector #684, DOC #120 confirmed that there should have been documentation for the specific shifts for resident #018. [s. 110. (7) 7.]

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Issued on this 13th day of March, 2018

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

Original report signed by the inspector.