Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2019	2019_822613_0004	017724-19	Complaint

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 5 - 8, 2019.

The following complaint was inspected during this inspection:

One Complaint that was submitted to the Director regarding allegations of resident to resident abuse.

A concurrent Critical Incident System Inspection #2019_822613_0005 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Executive Director of Care (EDOC), Directors of Care (DOCs), Infection Prevention and Control (IPAC) Co-ordinator/Staff Educator, Behavioural Supports Ontario RPN (BSO RPN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation files, and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the matters referred to in subsection (1) were evaluated and update in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #613 reviewed the licensee's policy titled, "Responsive Behaviours" (RC-17-01 -04), which indicated the policy was last updated on February 2017.

During various interviews with the Administrator, Director of Care #100 and IPAC Co-ordinator/Staff Educator, they all verified that that the licensee's policy titled, "Responsive Behaviours" (RC-17-01-04) last updated February 2017, was the licensee's most current policy.

The Licensee's "Responsive Behaviours" policy had not been reviewed or revised since February 2017. [s. 53. (3) (b)]

2. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #613 reviewed a complaint that was submitted to the Director, related to an allegation of resident to resident abuse.

A review of a Critical Incident (CI) report that was submitted to the Director, identified that there had been an unwitnessed altercation between resident #001 and resident #002, resulting with injuries to resident #001. The CI report also indicated that resident #002 had previous altercations involving other residents, but the altercations did not result in any injuries to the other residents.

A review of the licensee's policy titled, "Responsive Behaviours" (RC-17-01-01) last updated February 2017, identified that care staff were to provide close observation of the resident with responsive behaviours and document those behaviours in the Point of Care (POC) and Dementia Observation System (DOS) and complete the documentation of each episode of behaviour on each shift for the resident observed to display responsive behaviours. The care staff were to use DOS "per episode documentation" to understand the frequency of the behaviour.

A review of the Physician's Orders sheets titled, "Medical Pharmacies – Digital Prescriber's Orders" identified that the doctor had ordered Dementia Observation System (DOS) Tool, to asses resident #002's responsive behaviours to determine the occurrence, frequency and duration of behaviours of concern, for a seven day period. The review indicated that the DOS had been ordered, by the physician, on two specific dates in September 2019 and one specific date in October in 2019.

A review of resident #002's health care records identified that the DOS had not been initiated by staff until a specific date in October 2019, 29 days after it had initially been ordered by the physician. The Inspector reviewed two sheets titled, "Dementia Observation System/Behaviour Mapping". The first DOS was dated for seven specific days in October 2019, and the documentation was incomplete. There was no documentation on five dates and specific time frames in the seven day assessment

period.

The second DOS was dated for another seven specific dates in October 2019, and the documentation was also incomplete. There was no documentation on three dates and specific time frames in the seven day assessment period.

A sheet titled, "Nurse Practitioner/Physician Communication & Progress Note Record" dated on a specific date in October 2019, and written by BSO RPN #103, identified that the "DOS was partially completed".

During interviews with PSW #104 and PSW #106, both stated they were required to complete hourly documentation on the DOS during their scheduled shifts.

During an interview with RPN #105, they confirmed the DOS was incomplete and that all dates and times should have been completed, as well, the RPN stated the DOS should have been completed when ordered by the physician.

During an interview with BSO RPN #103, they confirmed DOS had been ordered three times by the physician and they were unsure why it had not been initiated. The BSO RPN stated the DOS should have been started when ordered. They further verified that the first DOS documentation dated for seven specific dates in October 2019, was incomplete and that they had put another DOS document on the unit to be completed dated for seven specific dates in October 2019, which was also incomplete.

During an interview with DOC #100, they reviewed a copy of the doctor's orders for resident #002 and a copy of both the DOS sheets for October 2019 and confirmed that staff had not followed the doctor's orders and initiated the DOS on the dates it was ordered. The DOC confirmed that the DOS documentation had been incomplete and that the RPNs were expected to initiate DOS documentation as ordered the physician. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 13th day of November, 2019

[redacted]

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

Original report signed by the inspector.