Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_099188_0015
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Apr 25, 26, 27, 30, May 10, 2012
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:

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

A previous compliance order was issued under s.6 2012_099188_0005, CO #005.

The licensee shall review and revise the written plan of care for two identified residents. Their plans of care shall set out clear direction to staff and others who provide direct care to the residents. The licensee shall ensure that staff are kept aware of the contents of the plans of care and that the care is provided as set out in the plans. The licensee shall ensure the plans of care for all residents in the home provide clear direction to staff, the staff and others who provide direct care to the residents are aware of the care requirements and the care is provided as specified in the plan.

Grounds / Motifs :

1. Inspector reviewed the plan of care for a resident. Inspector noted it identifies this resident is to use a manual wheelchair while in the home at all times and only use the electric wheelchair when leaving the building. Inspector spoke with staff and the resident, all of which confirmed that the resident uses the electric wheelchair at all times. Inspector reviewed the health care record and noted a driving assessment for an electric wheelchair was completed. The plan of care does not reflect the resident's use of the electric wheelchair within the home. The licensee failed to ensure that the resident is assessed and the plan of care reviewed and revised when the resident care needs change. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)] (188)
2. Inspector reviewed the health care record of a resident. Inspector noted that the resident was not to be using an electric wheelchair in the home, only for use to get outdoors and outside of the building prior to the driving assessment being completed. Inspector noted that the resident sustained an injury while using the electric wheelchair in the home, despite it being contraindicated in the plan of care. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (188)
3. Inspector reviewed the plan of care for a resident. Inspector noted the plan of care identifies the resident as using a Maxi (total) lift and not to weight bear. Inspector noted a physiotherapist assessment following a change to the resident's weight bearing status that identifies use of a Chorus (sit-stand) lift and Maxi to be used PRN and that the resident is able to weight bear. This change in care needs is not reflected in the plan of care. The licensee failed to ensure that a resident is reassessed and the plan of care reviewed and revised when there is a change in care needs or the care set out in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6 (10)(b)] (188)
4. Inspector reviewed the plan of care for a resident. Inspector noted conflicting information related to how this resident transfers. Inspector noted the care plan document identified this resident uses a Maxi (total) lift for transfers and toileting. Inspector noted the Kardex document identifies this resident uses a Maxi lift for transfers however under the toileting section it is hand written that the resident may use a Chorus (sit-stand) lift. Inspector spoke with a PSW who identified that currently the resident uses a Chorus (sit-stand) lift for all transfers and that the resident is not toileted using any lift and currently is using incontinent products for containment. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
5. Inspector reviewed the plan of care for a resident. Inspector noted a fall prevention intervention for use of hip protectors. Inspector noted the resident was not wearing hip protectors when observed. Inspector spoke with a PSW who confirmed the resident was not wearing hip protectors and identified that the resident had never worn hip protectors. The licensee failed to ensure the care is provided to the resident as outlined in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (188)
6. Inspector reviewed the plan of care for a resident. Inspector noted an intervention related to medication administration. Inspector noted this intervention was initiated following a meeting held with the resident's SDM. Inspector observed during the noon medications pass as the RPN administered the resident's medications and did not follow the intervention. Inspector observed during the am medication pass as the RPN administered the resident's medications and did not follow the intervention. Inspector reviewed the MAR noting the use of the intervention was not consistently documented. The licensee failed to ensure the care is provided to the resident as outlined in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (188)
7. Inspector spoke with an RPN related to a resident's diabetic management. The RPN identified that when administering insulin that usually they rotates sites. Inspector inquired about recording the site on the MAR and the RPN identified this is not really followed as regular staff work the unit and they know where they last administered the insulin. When inspector identified the plan of care states the site needs to be recorded on the MAR the RPN confirmed awareness of the intervention however was under the impression that the intervention was no longer in place. The licensee failed to ensure that staff who provide direct care to the resident are kept aware of the contents of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(8)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 18, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 10th day of May, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 25, 26, 27, 30, May 10, 2012	2012_099188_0015	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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Executive Manager of Nursing Care Services, Directors of Nursing, Registered Nursing staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) conducted a walk through of various resident care areas, observed staff interactions with residents, reviewed various policies and procedures and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Dining Observation

Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1.Inspector spoke with an RPN related to a resident's diabetic management. The RPN identified that when administering insulin that usually they rotates sites. Inspector inquired about recording the site on the MAR and the RPN identified this is not really followed as regular staff work the unit and they know where they last administered the insulin. When inspector identified the plan of care states the site needs to be recorded on the MAR the RPN confirmed awareness of the intervention however was under the impression that the intervention was no longer in place. The licensee failed to ensure that staff who provide direct care to the resident are kept aware of the contents of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(8)]
2. Inspector reviewed the plan of care for a resident. Inspector noted an intervention related to medication administration. Inspector noted this intervention was initiated following a meeting held with the resident's SDM. Inspector observed during the noon medications pass as the RPN administered the resident's medications and did not follow the intervention. Inspector observed during the am medication pass as the RPN administered the resident's medications and did not follow the intervention. Inspector reviewed the MAR noting the use of the intervention was not consistently documented. The licensee failed to ensure the care is provided to the resident as outlined in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
3. Inspector reviewed the plan of care for a resident. Inspector noted a fall prevention intervention for use of hip protectors. Inspector noted the resident was not wearing hip protectors when observed. Inspector spoke with a PSW who confirmed the resident was not wearing hip protectors and identified that the resident had never worn hip protectors. The licensee failed to ensure the care is provided to the resident as outlined in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
4. Inspector reviewed the plan of care for a resident. Inspector noted conflicting information related to how this resident transfers. Inspector noted the care plan document identified this resident uses a Maxi (total) lift for transfers and toileting. Inspector noted the Kardex document identifies this resident uses a Maxi lift for transfers however under the toileting section it is hand written that the resident may use a Chorus (sit-stand) lift. Inspector spoke with a PSW who identified that currently the resident uses a Chorus (sit-stand) lift for all transfers and that the resident is not toileted using any lift and currently is using incontinent products for containment. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
5. Inspector reviewed the plan of care for a resident. Inspector noted the plan of care identifies the resident as using a Maxi (total) lift and not to weight bear. Inspector noted a physiotherapist assessment following a change to the resident's weight bearing status that identifies use of a Chorus (sit-stand) lift and Maxi to be used PRN and that the resident is able to weight bear. This change in care needs is not reflected in the plan of care. The licensee failed to ensure that a resident is reassessed and the plan of care reviewed and revised when there is a change in care needs or the care set out in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]
6. Inspector reviewed the health care record of a resident. Inspector noted that the resident was not to be using an electric wheelchair in the home, only for use to get outdoors and outside of the building prior to the driving assessment being completed. Inspector noted that the resident sustained an injury while using the electric wheelchair in the home, despite it being contraindicated in the plan of care. The licensee failed to ensure that the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
7. Inspector reviewed the plan of care for a resident. Inspector noted it identifies this resident is to use a manual wheelchair while in the home at all times and only use the electric wheelchair when leaving the building. Inspector spoke with staff and the resident, all of which confirmed that the resident uses the electric wheelchair at all times. Inspector reviewed the health care record and noted a driving assessment for an electric wheelchair was completed. The plan of care does not reflect the resident's use of the electric wheelchair within the home. The licensee failed to ensure that the resident is assessed and the plan of care reviewed and revised when the resident care needs change. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]

Additional Required Actions:

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

Issued on this 23rd day of May, 2012

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