



**Ministry of Health and
Long-Term Care**

**Ministère 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) : DIANA STENLUND (163)

Inspection No. /

No de l'inspection : 2013_139163_0004

Log No. /

Registre no: 1391-12, 1393-12,1394-12

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : May 6, 2013

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 # / **Order Type /**
Ordre no : 001 **Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #006;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an

independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

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.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that resident #1322 is allowed to freely come and go from their resident home area as appropriate, and that their rights are fully respected and promoted, especially with respect to their right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Grounds / Motifs :



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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

1. Five previous written notifications (WNs) of non-compliance have been issued related to this same area of the legislation, including a voluntary plan of correction (VPC) in December 2011 during inspection #2012-099188-0034 and two compliance orders (CO); one in December 2011 during inspection #2012-054133-0030 and the other in July 2012 during inspection #2012-099188-0027.

1. Inspector was present on one of the resident units when resident #1322 was observed to be in the process of leaving the unit, escorted by their POA. Inspector observed that the resident and their POA were stopped by a staff member just prior to leaving the unit and informed that they could not leave due to the influenza A outbreak on their unit. The inspector was made aware by a supervisory staff member that residents and family members may come and go off the unit during an outbreak, however staff are required to advise them about infection control practices. The licensee has not ensured that this resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.] (163)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 17, 2013



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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



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Order(s) of the Inspector
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section 154 of the *Long-Term Care
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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.



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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, 11^e 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.



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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 6th day of May, 2013

Signature of Inspector / *Diana Stenlund, #163*
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANA STENLUND

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



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2013	2013_139163_0004	1391-12, 1393- 12,1394-12	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

DIANA STENLUND (163)

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): Feb 12-15, and 19-20, 2013.

The following Ministry of Health and Long-Term Care logs were reviewed as part of this inspection:

**S-001391-12
S-001393-12
S-001394-12
S-001395-12
S-001356-12
S-001322-12
S-000028-13
S-000044-13**

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Nursing Services, Occupational Health and Infection Prevention and Control Coordinator, registered nursing staff, personal support workers, residents and family members.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions and provision of care, reviewed resident health care records and home policies.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Laundry
Contenance Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Recreation and Social Activities**



Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector was present on one of the resident units when resident #1322 was observed to be in the process of leaving the unit, escorted by their POA. Inspector observed that the resident and their POA were stopped by a staff member just prior to leaving the unit and informed that they could not leave due to the influenza A outbreak on their unit. The inspector was made aware by a supervisory staff member that residents and family members may come and go off the unit during an outbreak, however staff are required to advise them about infection control practices. The licensee has not ensured that this resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 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. 27. Care conference

Specifically failed to comply with the following:

- s. 27. (1) Every licensee of a long-term care home shall ensure that,**
- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
 - (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
 - (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**
-

Findings/Faits saillants :

1. Inspector reviewed resident health care records in four resident home areas. It was noted that for seven residents, there was no documentation of an annual care conference with the interdisciplinary team. The licensee has not ensured that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and a record is kept of the date, the participants and the results of the conferences. [s. 27. (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 for residents #028, #105, #111, #116, #126, #102 and #106, a care conference of the interdisciplinary team providing the resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. Inspector interviewed supervisory staff members about the provision of a written staffing plan for nursing and personal support services. It was reported to the inspector that the home has not developed a written staffing plan for this group of staff. The licensee has not ensured that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). [s. 31. (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 a written staffing plan is developed for the programs referred to in clauses (1)(a) and (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service



Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. Inspector observed lunch meal service on one of the units of the first floor. A staff member was noted to be kneeling beside a table while feeding resident #115. On another day, inspector observed meal service where two staff were standing while feeding residents who were seated. The licensee has not ensured that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating. [s. 73. (1) 10.]

2. Inspector observed lunch meal service on one of the units of the first floor. During the meal service it was observed by the inspector that a staff member assisted resident #1391 with the first two spoons of their entrée and then left the resident unattended at the table for 17 minutes. The resident did not receive any assistance with their meal during this time. When the same staff returned to the resident, the remaining entrée was removed and a dessert was placed in front of the resident. Inspector noted in resident's #1391 plan of care that if resident is not eating independently, staff are to feed the resident.

Inspector observed lunch on the same unit on a subsequent day. During the meal service it was observed that a staff member who assisted resident #103 left the table for extended periods of time (10-15 min x 2 occasions) and resident was not offered assistance by another staff. Inspector noted that resident's #103 plan of care requires 1 staff to assist the resident with eating and drinking. The licensee has not ensured that, no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. [s. 73. (2) (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 staff use proper feeding techniques to assist resident #115 with eating, and that residents #103 and #1391, who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, 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. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :



1. Inspector reviewed the health care record of resident #1356 who had respiratory health issues. Inspector noted from the documentation that this resident had a medication order, prn every 4 hours to address such health concerns. The resident's health care records indicate that on a particular day at 1500hr the resident was observed by a family member to be having difficulty breathing; a registered staff reported to the family member that according to a review of the MAR (medication administration record) the last dosage of the medication was at 0100hr. Inspector noted an entry in the health care record, including the Critical Incident report, indicating that the resident was administered two subsequent dosages after 0100hr however these two treatments were not documented at the time of the medication being administered. Inspector reviewed the home's medication management policy where it requires that registered staff initial MAR after the medication is administered. The licensee has not ensured that the home's written policies and protocols are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 114. (3) (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 the home implements their medication management policy, specifically with regards to documentation and administration of medications, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :



1. Inspector reviewed documentation covering a three month period on three resident home areas with regards to resident attendance at activities. Inspector noted that in two of the three home areas reviewed, there were 19 residents without any attended activities recorded, and there was no documentation to indicate the resident's response to the interventions, for example, a check mark for attending the activity or R for refused as coded on other activity attendance forms reviewed. The licensee has not ensured that any actions taken with respect to a resident under a program (recreation and social activities), including assessments, reassessments, interventions and the resident's responses to interventions are documented. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).**

Findings/Faits saillants :

1. Inspector interviewed a staff member about observations made on one of the units where there was an outbreak with influenza A posted. Inspector noted that some residents and family members freely exited and re-entered the unit while others were informed that they could not leave the unit. The inspector was made aware that there is no documentation that clearly defines staff responsibilities during an outbreak with regards to advising family and residents about entering and exiting the unit. The licensee has not ensured that there is in place, an outbreak management system that includes defined staff responsibilities. [s. 229. (8) (a)]



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 6th day of May, 2013

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

Diana Jenlund, #163