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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 15, 2013	2013_246196_0005	S-000212-13,S-000266-13	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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 15, 16, 17, 18, 19, 2013

During the course of the inspection, the inspector(s) spoke with the Senior Manager, Director of Care (DOC), Clinical Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and family members

During the course of the inspection, the inspector(s) conducted a walk through of all resident care areas, observed the provision of care and services to residents, observed the staff to resident interactions, reviewed the health care records of several residents

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

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 health care records for resident #012 were reviewed by the inspector. The progress notes on a particular day in June 2013 identify resident #012 being verbally threatening towards resident #013 as it relates to that resident entering their room. The care plan and the kardex were reviewed by the inspector and by staff member #100 for information regarding this particular behavioural trigger, that of the co-resident entering resident #012's room. No reference was noted in the plan of care of this behavioural trigger.
Resident #012 was demonstrating responsive behaviours on a particular day in June 2013, namely verbally threatening a co-resident #013 and the behavioural trigger of this resident entering their room was not identified.
Six days later, resident #012 physically assaulted co-resident #013, resulting in injury requiring transfer to hospital for assessment and treatment. According to the progress notes, resident #012 reported that they had caused injury to the co-resident because they had come into their room and they had told this co-resident before, not to come in there.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; [s. 53. (4) (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 that ensures that for resident #012 demonstrating responsive behaviours, the behavioural triggers for this resident are identified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. In June 2013, a Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) outlining a physical assault by resident #012 towards resident #013 which resulted in injury and transfer to hospital.
The progress notes of resident #012 were reviewed and noted a previous verbal threat towards this same resident earlier in June 2013, for having entered their room. The care plan and kardex were also reviewed and did not identify steps that could be taken to minimize the risk of altercations and potentially harmful interactions between these two residents.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions. [s. 54. (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 that ensures that steps are taken to minimize the risk of altercations and potentially harmful interactions specifically between resident #012 and #013, including, identifying and implementing interventions, to be implemented voluntarily.

Issued on this 23rd day of October, 2013

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

Lauren Lahuren #196.