Ontario

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

Ministére 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

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) :	JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2014_281542_0004
Log No. / Registre no:	S-000447-13, 366-13, 489-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 6, 2014
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:

Ontario

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

Ministére 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

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. (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).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, specifically related to residents # 336, #447 and #489.

Grounds / Motifs :

1. A previous history of non compliance with s. 6. (1) (c) was issued as part of a Director's Referral (DR) in July 2012 during inspection # 2012_099188_0027.

Inspector observed resident # 489 sitting in a tilt wheel chair wearing a seat belt on February 6, 2014 @ 1015 hr. Upon review of resident # 489's most current plan of care it was noted that there was no documentation to support the use of the seat belt. Staff member # 104 informed Inspector that resident # 489 uses the seat belt as she prefers to have it on. (542)

2. Inspector reviewed resident # 447's most current plan of care on Feb 5-6, 2014 which indicated the following; walks with her walker on the unit, independent for locomotion on unit, restraints – secure unit to prevent incidences of elopement. Staff member # 103 informed Inspector during an interview that the resident does not ambulate. Inspector observed resident #447 propelling around a non-secured unit in a wheel chair. (542)

3. Inspector reviewed resident # 366's most current plan of care on February 5, 2014. Inspector noted that the kardex which is used by the direct health care providers described the resident as follows: walks only with staff with physical assist and physio, extensive assist by 1 staff to walk in room/corridor, wheel chair primary mode of locomotion, posey hipsters when ambulating. Inspector observed resident # 366 to be ambulating independently without staff's assistance on the unit. Inspector interviewed staff members # 100, 101 and 102 all of which stated that resident walks independently and wears the posey hipsters while ambulating.
The licensee failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to the resident. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 19, 2014

Ontario

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

Ministére 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

Order # / Ordre no : 002

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. (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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically related to resident # 366.

Grounds / Motifs :

1. A history of non compliance with s. 6. (7) was previously issued in July 2012 as a Compliance Order (CO) where a Director's Referral (DR) followed during inspection # 2012_099188_0027. In May 2013 during inspection # 2013_139163_0005 another CO was issued. In August 2013 s. 6(7) was placed back into compliance during inspection # 2013_139163_0020.

Inspector reviewed resident # 366's most current plan of care which indicated that resident was to wear "posey hip protectors" while ambulating. This particular resident had a history of falls according to the progress notes which indicated that during the month of August 2013 resident sustained several falls. On February 6, 2014 it was noted by Inspector and confirmed by staff member # 100 that resident # 366 was not wearing the posey hip protectors while ambulating as indicated on their plan of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (542)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 19, 2014

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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.

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, 11e 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.

Ontario

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

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 March, 2014

Signature of Inspector / Signature de l'inspecteur : Jlauricella #542

Name of Inspector / Nom de l'inspecteur : Jennifer Lauricella

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

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2014	2014_281542_0004	S-000447-13, 366-13, 489-13	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

JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5-6, 2014

The following were the assigned logs:
S-000447-13, S-000366-13, S-000489-13

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents.

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 staff to resident interactions and reviewed health care records for several residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(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).

Findings/Faits saillants :

1. Inspector reviewed resident # 366's most current plan of care on February 5, 2014. Inspector noted that the kardex which is used by the direct health care providers described the resident as follows: walks only with staff with physical assist and physio, extensive assist by 1 staff to walk in room/corridor, wheel chair primary mode of locomotion, posey hipsters when ambulating. Inspector observed resident # 366 to be ambulating independently without staff's assistance on the unit. Inspector interviewed staff members # 100, 101 and 102 all of which stated that resident walks independently and wears the posey hipsters. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector reviewed resident # 447's most current plan of care on Feb 5-6, 2014 which indicated the following; walks with her walker on the unit, independent for locomotion on unit, restraints – secure unit to prevent incidences of elopement. Staff member # 103 informed Inspector during an interview that the resident does not ambulate. Inspector observed resident #447 propelling around a non-secured unit in a wheel chair. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector observed resident # 489 sitting in a tilt wheel chair wearing a seat belt on February 6, 2014 @ 1015 hr. Upon review of resident # 489's most current plan of care it was noted that there was no documentation to support the use of the seat belt. Staff member # 104 informed Inspector that resident # 489 uses the seat belt as she prefers to have it on. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Inspector reviewed resident # 366's most current plan of care which indicated that resident was to wear "posey hip protectors" while ambulating. This particular resident had a history of falls according to the progress notes which indicated that during the month of August 2013 resident sustained several falls. On February 6, 2014 it was noted by Inspector and confirmed by staff member # 100 that resident # 366 was not wearing the posey hip protectors while ambulating as indicated on their plan of care. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 7th day of March, 2014

[redacted]

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

J Lauricella #542