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
Apr 3, 2014	2014_281542_0008	S-000075-14	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

JENNIFER LAURICELLA (542)

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): March 10 and 11, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Director of Resident and Volunteer Services, Registered Staff, Personal Support Workers (PSWs), Residents and Family members.

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

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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 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. Inspector reviewed resident # 76's progress notes over a period of 2 months with regards to the resident's wandering behavior. Progress notes indicate that the intervention "re-direction" is used and is most often ineffective. Progress notes also indicated that the resident does not know own limits and will physically touch co-residents causing them to become agitated. Inspector reviewed the Responsive Behavior Record for a one week period, that is completed by the Personal Support Workers (PSWs). On the document the PSW's describe the behavior, what was happening just before the behavior, who was present and what was done (intervention) and whether it was effective. The behavior listed during the above time frames were wandering, entering resident's rooms and or poking residents and the intervention was re-direction. PSW's also documented that this intervention was not effective.
On March 10, 2014 Inspector observed resident # 76 throughout the day to be wandering between two units and at times near the front exit of the building. Resident # 76 would open a co-resident's door, peek in and then shut the door or resident would enter co-resident's room. At one point the Inspector over heard a co-resident yell at resident # 76 to get out of their room.
On March 11, 2014 Inspector interviewed residents on the unit, all of which stated that they wish that the behavior of resident # 76 would stop and that the behavior can be frustrating. One resident stated that they cannot leave their personal items out as resident # 76 will take them. They also stated that they are fearful that resident # 76 will get injured by another resident as resident # 76 will physically touch other residents and startle them, which could cause someone to strike out at resident # 76.
Inspector interviewed PSW # 100 and was informed that the staff try to re-direct resident # 76 away from co-resident's rooms, and that this resident will at times physically touch co-residents. PSW also stated that the wandering behavior has

increased and that resident # 76 is at risk for injury as they might physically touch a co-resident causing them to retaliate. PSW # 101 was also interviewed and stated to the inspector that resident # 76 doesn't stop wandering and entering co-resident's rooms and sometimes this occurs during the whole night. PSW # 101 stated that everyone just usually tries to re-direct resident # 76 or put a movie on for resident to watch. Inspector interviewed Director of Resident and Volunteer Services on March 11, 2014, and was informed that the activity staff are just getting on board with providing 15 minutes/day of activities to resident # 76. The licensee has documented that re-direction is an intervention to address resident # 76's ongoing wandering behavior, however a review of the resident's health care record and interviews with staff indicate this intervention has not been effective and the resident has not been reassessed.

The licensee has failed to ensure that, for each resident demonstrating responsive behaviors, (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). [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 behaviors, specifically related to resident # 76, 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 4th day of April, 2014

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

Jennifer Lauricella