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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2017	2016_336620_0023	015919-16	Resident Quality Inspection

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

ALAIN PLANTE (620), AMY GEAUVREAU (642), RYAN GOODMURPHY (638), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 08-12, August 15-19, and August 22-26, 2016

The inspector(s) conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Nursing Services (EDOC), Directors of Nursing (DON), Manager of Infection Control (MIC), Assistant Manager of Environmental Services (AMES), Staff Educator, Registered Dietitian (RD), Resident Assessment Instrument (RAI) Co-ordinator, Manager of Housekeeping and Laundry (MHL), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Activity Aids, Housekeeping staff, Behavioural Supports Ontario (BSO) staff, family members, and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #638 conducted a review of a critical incident (CI) which was submitted to the Director. The CI indicated that resident #020 experienced a fall. The CI also indicated that the resident used a specific assistive aid and that it was not applied as specified within their plan of care because the assistive aid was soiled.

A review of resident #020's care plan, which had been in effect at the time of the fall, indicated that the resident required a specific assistive aid to be in place at all times, to reduce the risk of injury from falls.

In an interview with Inspector #638, RPN #124 stated that the interventions within the plan of care were expected to be implemented as laid out within the plan. Resident #020's assistive aid should have been in place at all times. The home ensured that the specific assistive aids were available at all times.

Inspector #638 interviewed DON #125 who indicated that the assistive aid was to be utilized by resident #020 at all times as per the plan of care. They stated that the resident only had one assistive aid and it had not been applied at the time of the fall.

In a concurrent interview, DON #125 stated that specific assistive aids were available to staff whenever resident stock had become soiled or was no longer appropriate for use. The DON went on to state that the registered staff should have requested a replacement

assistive aid in order to ensure that the interventions were provided as laid out within the plan of care.

During an interview with Inspector #638, DON #125 stated that the assistive aid was not worn at the time of the fall. They noted that there should have been sufficient supplies available in order to ensure that the care had been provided as identified within the plan of care. The DOC indicated that the registered staff should have requested an extra assistive aid in order to ensure that the care was provided as specified in the plan of care. [s. 6. (7)]

2. A CI was submitted to the Director; the CI indicated that resident #022 had fallen and that a specific fall prevention device was required to be in place and activated and it was not .

Inspector #642 reviewed resident #022's care plan. The care plan had a fall prevention focus. As an intervention to prevent falls, resident #022 was to utilize a specific device. The device was intended to prevent falls.

Inspector #642 reviewed a progress note documented by RPN #140. The documentation stated that resident #022's device was in place but had not been activated at the time of the fall.

Inspector #642 interviewed PSW's #126 and #127 on August 24, 2016, they stated that they had discovered resident #022 after their fall. PSW #126 stated that the specific device was not activated; therefore, it could not have prevented the fall.

Inspector #642 interviewed DON #129 who stated that it was the home's expectation that the specific device was to be utilized and activated to help prevent falls. In an interview with the Administrator, they stated that resident #022's fall prevention device should have been in place and activated as indicated in the care plan. [s. 6. (7)]

3. Inspector #543 reviewed two CIs submitted to the Director. Both CIs described that resident #024 was observed by staff to be displaying sexually inappropriate behaviour toward other residents in a common are of the home.

A review of resident #024's care plan identified a focus specifically related to sexually responsive behaviours. The care plan identified specific interventions that were to be implemented.

Inspector #543 conducted observations of resident #024 and identified that on four occasions the interventions to address resident #024's inappropriate sexual behaviours were not being implemented as indicated in the plan of care.

Inspector #543 interviewed RPN #103 who stated that it was the expectation of the home that all staff review each resident's care plan before their shift.

Inspector #543 interviewed PSW #138. They stated that resident #024 displayed sexually inappropriate behaviours toward staff; however, they had no knowledge of sexual behaviours exhibited toward other residents. They also stated that staff were expected to review resident care plans daily and sign indicating that they had done so.

On August 25, 2016, Inspector #543 interviewed PSW #139, who replied, "I know nothing" when asked if they could elaborate on resident #024's sexually responsive behaviours. [s. 6. (7)]

4. The licensee has failed to ensure that resident #008 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #543 reviewed resident #008's most recent care plan, specifically related impaired skin integrity. The care plan had a focus that identified a wound. The interventions in the same care plan indicated the resident had a different type of wound.

A review of resident #008's most recent MDS assessment, indicated the presence of a specific type of wound. The resident's Weekly Wound Assessment identified that the resident had different type of wound in a certain location.

In an interview with RPN #108 they stated that it was the responsibility of the registered staff to update the care plan. They also verified that anytime there was a change in the resident's condition or care needs the care plan must be updated. They noted that resident #008 had a wound since the date of admission.

In an interview with the RAI Coordinator they stated that they would update resident care plans on a quarterly and annual basis. If there were changes in a resident's condition or changes to their care needs between quarterly reviews, it was the responsibility of the registered staff on the units to update accordingly. They verified that resident #008's plan

of care was not updated to reflect a change in the nature of the resident's wound. [s. 6. (10) (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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #620 reviewed a CI submitted to the Director which described an incident of staff to resident abuse; whereby, PSW #130 reported in a voice mail to DOC #125 that PSW #131 had committed an act of physical abuse upon resident #031.

Inspector #620 conducted a review of the home's investigation which revealed that PSW #130 witnessed what they suspected to be a physical abuse committed upon resident #031 by PSW #131. PSW #130 did not immediately report the incident; but rather, PSW #130 left a voice mail message for DOC #132 detailing the alleged abuse.

The home's investigation notes further detailed that PSW #131 was disciplined as a result of the alleged incident of abuse. PSW #130 was counselled as a result of their failure to report the alleged incident of abuse immediately.

Inspector #620 reviewed the home's zero tolerance of abuse and neglect policy titled, "Zero Tolerance of Abuse and Neglect Program" with a last revision date of April 2016. Under the subheading, "Reporting" the policy advised staff that, "Any employee who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/ reporting manager or if unavailable, the most senior Supervisor on shift at the time."

On August 24, 2016, Inspector #620 interviewed the Administrator who verified that PSW #131 received disciplinary action as a result of the alleged incident of abuse. They also stated that PSW #130 was counselled for their failure to immediately report the alleged incident of abuse. The Administrator stated that all incidents of suspected or witnessed abuse were to be reported immediately to the home's management. [s. 20. (1)]

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 ensuring that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that the heating, ventilation and air conditioning systems were cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

During the Resident Quality Inspection, Inspector #638 and #630 conducted resident interviews and it was identified that both resident #007, and #012 stated that the temperature in the home were too hot.

Inspector #620 reviewed a complaint received by the MOHLTC. The complainant alleged that resident #014 was suffering from "extreme heat" in their room and that other residents' health was also at risk due to the extreme temperatures.

Inspector #620 also reviewed a CI that was submitted to the Director. The report indicated that the home had received a letter from a family member that detailed

concerns with regards to resident #032 and with the functionality of the home's heating, ventilation, and cooling system (HVAC).

Inspector #620 gathered temperature readings throughout the home. It was identified that a specific area of the home had the highest temperatures. A weather metering device was placed in resident #014's room; the meter took continuous temperature measurements for three days. The subsequent measurements revealed that the resident's room measured an average temperature of 27.1 °C. The maximum temperature reading was measured at 29.7 °C.

During an interview with inspector #620 the Assistant Manager of Environmental Services (AMES) was asked whether temperature reading were being collected throughout the home. The AMES provided the Inspector with temperature monitoring logs. A review of the temperature monitoring logs identified that the temperature readings on certain days were as high as 29.5 °C.

Inspector #620 interviewed the AMES who stated that the home became aware of mechanical failures in the HVAC system in late May, 2016. They also noted that the mechanical failures resulted in an inability for the HVAC system to appropriately cool the home; specifically, areas of the home that were distant to the core of the building. They specified that a specific area of the home was most susceptible to increased temperatures.

A review of the home's documentation related to the mechanical issues with the home's HVAC system revealed that the home received a quote for services from a local HVAC service contractor on May 27, 2016. A review of the document identified that the local HVAC service contractor had not received an accepted purchase order until July 05, 2016, more than five weeks after the HVAC failures were identified.

Inspector #620 reviewed a notice of compliance report served to the home on August 05, 2016. In the report an Occupational Health and Safety Inspector/Provincial Offences Officer served the home under the Occupation Health and Safety Act, 1990, s. 25 (1)(b). The order stated that, "you are required to comply with the order(s) /requirement(s)... An employer shall ensure that the equipment, the HVAC SYSTEM is maintained in good condition – at the time of the visit the system had experienced failure and was not functioning properly." The compliance date for the order was August 08, 2016.

Internal correspondence reviewed by Inspector #620 revealed that on July 05, 2016, the

home's Administrator notified the members of the senior management team that, certain areas of the home were "unbearable." The response from the management team stated, "I wouldn't wait any longer. You have two quotes."

In subsequent interview with the AMES they stated that the home had difficulty acquiring three quotes and that the home's procurement process required three in order to proceed with the repair. As a result, the home did not proceed with accepting a tender for the repair until July 05, 2016. On the same date the parts to complete the repair were ordered with an expected delay of six to eight weeks. The AMES was asked whether there were any maintenance staff in the home that were certified to inspect the home's HVAC system. The AMES stated that there were no certified staff and that they utilized a local HVAC contractor to complete an inspection on an annual basis. The AMES stated that they were unaware of the requirement to have a certified individual inspect the HVAC system every six months. [s. 90. (2) (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 ensuring that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that the heating, ventilation and air conditioning systems are cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection, to be implemented voluntarily.

WN #4: 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to, have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observations made by Inspector #638 in a specific area of the home indicated that the electronic medication administration record (eMAR) was left unlocked and unattended by RPN #120 on a computer screen. Inspector #638 observed that people were able to view the personal health information (PHI) on the screen.

Further observations were made in other areas of the home. As a result Inspector #638 observed that an eMAR screen was also left unlocked and unattended by RPN #121 in the dining area and residents and family members could view the PHI. RPN #123 was also observed leaving the eMAR screen unlocked and unattended during a medication pass. The unlocked eMAR screen was in a common area which was attended by residents and residents' family members and they were able to view the PHI.

In an interview with Inspector #638, RPN #120 stated that registered staff were expected to lock the eMAR screen anytime it was left unattended or not in use. They confirmed that they had not locked the eMAR screen as was required.

During an interview with Inspector #638, both the Administrator and the DOC stated that PHI was to be protected and kept confidential. The Administrator stated that the eMAR screen should have been locked at all times when left unattended in order to protect the residents' PHI. [s. 3. (1) 11. iv.]

Issued on this 8th day of February, 2017

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

Original report signed by the inspector.