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 # / No de registre	Type of Inspection / Genre d’inspection
Oct 13, 2017	2017_638609_0017	013263-17	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

CHAD CAMPS (609), JENNIFER LAURICELLA (542), LISA MOORE (613)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): July 24-28, July 31, August 1-4 and August 9-11, 2017.

Additional logs inspected during this RQI included:

Six complaints submitted to the Director related to resident care;

Seven critical incidents the home submitted to the Director related to resident falls;

One critical incident the home submitted to the Director related to improper care of a resident; and

One critical incident the home submitted to the Director related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Nursing (DONs), Director of Resident and Volunteer Services (DRVS), Educator, Maintenance Manager, Dietary Manager (DM), Registered Dietitian (RD), Chaplain, Scheduler, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Staff, residents and family members.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

8 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 written plan of care for each resident set out the planned care for the resident.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director. The CI report described how resident #015 had a fall that resulted in a significant injury.

A review of the home's internal investigation revealed that resident #015's specified intervention had not been applied at the time of the fall. The investigation notes identified that PSW #140 had not ensured that resident #015's specified intervention had been working correctly. PSW #140 admitted that they had not ensured that resident #015's specified intervention had been working correctly at the start of their shift.

During an interview with DOC #106, they confirmed that PSW #140 had not followed resident #015's care plan and should have ensured that the resident's specified intervention had been working.

A review of resident #015’s plan of care at the time of the incident found no indication in the plan that staff were to check the resident's specified intervention to ensure that it was working.

During the same interview with DOC #106, they stated that it was the home’s policy and expectation for staff to ensure that rounds were completed at the beginning of each shift to ensure the residents were safe and that specified interventions were working and that this should have been set out in resident #015's plan of care. [s. 6. (1) (a)]

2. Inspector #613 reviewed a CI report that was submitted to the Director. The CI report identified that resident #011 was physically responsive toward resident #012, which resulted in injury to resident #012.

A review of resident #011's health care records for a specified time frame, revealed the resident had additional altercations involving other residents as outlined:

On an identified day resident #011 grabbed resident #022 and threatened them, resulting in an injury to resident #022. Prior to the altercation, resident #011 was swinging a piece of equipment;
On an identified day resident #023 triggered resident #011, resulting in verbally and physically responsive behaviours toward resident #023;
On an identified day resident #024 triggered resident #011, resulting in verbally and physically responsive behaviours toward resident #024;
On an identified day resident #011 was verbally responsive towards other residents;
On an identified day resident #011 became verbally and physically responsive toward resident #024;
On an identified day resident #011 became verbally responsive toward resident #023, threatening them; and
On an identified day resident #011's responsive behaviours resulted in injury to resident #025.

During interviews with PSW #124, PSW #125 and PSW #139, they all informed the Inspector that resident #011 had a history of physically and verbally responsive behaviours towards other residents and that a trigger for the resident’s behaviour was a clearly identified cause. All PSWs stated they monitored resident #011’s whereabouts to avoid the identified cause and subsequently avoid further altercations.

On five separate days, resident #011 was observed with the identified cause. No staff were present for monitoring resident #011 or the identified cause.

The Inspector asked PSW #124 to show them where interventions were identified in the care plan regarding resident #011's identified responsive behaviour cause. PSW #124 and RPN #117 reviewed the care plan and confirmed that resident #011's care plan did not identify specific interventions for the identified cause.

During an interview with Behavioural Supports Ontario (BSO) RPN #135, they stated that BSO has been working with resident #011 and confirmed the care plan did not identify specific interventions on how to manage resident #011's identified cause of responsive behaviours.

A review of resident #011's plan of care identified a cause for the resident's physically responsive behaviour, but did not identify the interventions staff were to use to manage the physical and verbal responsive behaviours.

A review of the home's policy titled "Responsive Behaviours" last revised September 2010 identified that each resident displaying responsive behaviours would have their behaviour assessed and a resident focused plan of care would be developed and maintained that included resident specific interventions to address behaviours as well as strategies staff were to follow if the interventions were not effective.

During an interview with DOC #106 they informed the Inspector that they were aware of resident #011's previous physically and verbally responsive behaviours towards other residents. DOC #106 confirmed that specific interventions to manage resident #011's responsive behaviours should have been added to their plan of care. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director, which outlined concerns that resident #014 had sustained an injury of an unknown origin.

Inspector #609 reviewed a CI report submitted to the Director, which outlined how resident #014 was found with an injury of an unknown origin.

On a particular day, resident #014 was observed with no injury.

A review of resident #014’s plan of care found that on a previous particular day, DON #105 updated the plan of care with the injury resolved.

During an interview with resident #014’s SDM, they outlined concerns that they were not being informed when the resident’s condition and care changed.

A review of the home’s policy titled “Care Planning” date of origin September 2010 indicated that as the care plan was updated, the SDM was to be involved with and informed of the changes.

During an interview with DON #105, they verified that on a particular day, they updated resident #014’s plan of care resolving an injury that was implicated in a CI report. DON #105 further verified they did not notify the resident’s SDM until two days after the changes to the plan of care were implemented. [s. 6. (5)]

4. The licensee has failed to ensure that the resident 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.

A CI report was submitted to the Director, which outlined how resident #014 was found with an injury of an unknown cause.

Inspector #609 reviewed resident #014’s current plan of care which indicated that the resident had an injury and to follow the Treatment Administration Record (TAR).

A review of resident #014’s physician treatment order, indicated that a specified intervention was to be applied to the injury.

On a particular day, resident #014 was observed with no specified intervention and no injury.

During an interview with RPN #110, they verified that resident #014’s injury had resolved.

A review of the home’s policy titled “Care Planning” last updated December 2016

indicated that when the resident's status changed, the plan of care was to be updated to ensure that the plan reflected the current needs of the resident.

During an interview with the Administrator they verified that resident #014's injury had resolved and that the plan of care should have been revised. [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 to ensure that the written plan of care for each resident sets out the planned care for the resident as well as to 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 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Inspector #613 reviewed a CI report that was submitted to the Director on a particular day. The CI report identified that resident #011 became physically responsive, which resulted in injury to resident #012.

During a review of the home's internal investigation, the Inspector was unable to locate an amended CI report to identify that the results of the investigation and every action taken, had been reported to the Director.

During an interview with DOC #106, they confirmed that they had not reported to the Director the result of their investigation. [s. 23. (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 every investigation under clause (1) (a), and every action taken under clause (1) (b) is reported to the Director, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC).

On a particular day Inspector #609 observed PSW #115 laying down on their back in resident #018's bed. The PSW then rose from the resident's bed, walked out of the room and directly into another resident's room.

A review of the posted plan of care outside of resident #018's room indicated that all staff were to use specified precautions when in the resident's room.

A further review of resident #018's plan of care found that the resident had a specific diagnosis and that staff were to follow specified precautions when in the resident's room.

During an interview with RPN #117, they verified that staff were to follow specified precautions when caring for resident #018 or in the resident's room.

A review of the home's policy titled "Isolation" last updated September 2015 indicated that staff must practice precautions.

During an interview with PSW #115, they verified that resident #018 had specified precautions and that these should have been followed when in the resident's room.

During an interview with the home's Educator and IPAC lead, they verified that PSW #115 did not follow precautions on a particular day, when they were observed laying in resident #018's bed. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, 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:
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. The licensee has failed to ensure that resident's right to be treated in a way that respected their dignity was fully respected and promoted.

On a particular day, during a meal observation, Inspector #609 observed resident #019 being assisted to feed by PSW #132. The PSW was observed scooping off food that had fallen out of the resident's mouth and onto their clothes protector, back into the resident's dish. The PSW then fed it back to the resident.

On another particular day, resident #019 was assisted to feed by PSW #133. The PSW was observed scooping fallen food from the resident's clothes protector back into the resident's dish and continue feeding the resident from the same dish.

A review of the home's policy titled "Ontario Residents' Bill of Rights" last updated April 2017 indicated that every resident had the right to be treated with courtesy and respect, in a way that fully recognized the resident's individuality and respected the resident's dignity.

During an interview with PSW #132, they verified that there have been times when food has fallen onto resident #019's clothes protectors and was scooped up and fed back to the resident.

During an interview with PSW #133, they verified that scooping food from a resident's clothes protector and feeding it back to the resident would not be respecting or promoting the resident's dignity.

During an interview with DON #106 and the Dietary Manager (DM), they both verified that scooping fallen food up and feeding it back to a resident was disrespectful and undignified. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1.The licensee has failed to ensure that a written response was provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #609 reviewed three previous months of resident council meeting minutes and found no written responses from the home to concerns brought forward in Resident Council.

During an interview with the Council President (resident #018), they indicated they had been the President for approximately four to five years and could not recall ever receiving a written response from the home to concerns brought forward in Residents’ Council.

During an interview with the Director of Resident and Volunteer Services (DRVS), they verified they were the Assistant to the Residents’ Council. They described how the home’s process for dealing with concerns brought forward by Residents’ Council was for the DRVS to write them into emails to the appropriate department heads. Then at the next Residents’ Council meeting (which was usually the next month) the DRVS would verbally relay the department heads’ responses.

A review of the home’s policy titled “Resident’s Council” effective date June 2014 indicated that the Administrator was to respond in writing to Residents’ Council concerns within 10 days of receiving the minutes.

During an interview with the Administrator, a review of the Act was conducted as well as the home’s “Resident’s Council” policy. The Administrator verified that concerns brought forward by Council were to be responded to in writing within 10 days and that this had not occurred. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, were notified of the result of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation

Inspector #613 reviewed a CI report that was submitted to the Director. The CI report identified that resident #011 became physically responsive toward resident #012 on a particular day, which resulted in injury to resident #012.

A review of the home's internal investigation and resident #011's health care record did not identify that resident #011 and resident #012's substitute decision-makers had been notified of the results of the investigation immediately upon the completion of the investigation.

During an interview with DOC #106 they confirmed that they had not immediately notified both residents' substitute decision-makers of the results of the investigation. [s. 97. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than three business days after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to the hospital.

Inspector #613 reviewed a CI report that was submitted to the Director. The CI report described that on the morning of a particular day, resident #021 was found with identified injuries. The resident was sent to the hospital for further assessment as the cause of the injuries were unknown to staff.

A review of resident #021's health care records revealed that the resident was admitted to the hospital with significant injuries. Resident #021 returned to the home two days prior to the CI submission.

During an interview with the Administrator and DOC #105, they confirmed that the CI report was submitted late to the Director. The Administrator stated they had thought they had ten days to submit the CI report. [s. 107. (3.1) (b)]

2. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident or sooner if requested by the Director to make a report in writing to the Director setting out the description of events leading up to the incident.

Inspector # 613 reviewed a CI report that was submitted to the Director. The CI report described that resident #020 had a fall on a particular day that resulted in an injury.

On a particular day the Director had requested the licensee to amend the CI report to clarify resident #020's history of falls within the last six months, including dates and injuries. 51 days later the CI report had not been amended by the home.

A review of the fall progress notes for a specified time frame, identified that resident #020 had five falls prior to the fall that resulted in the resident's significant change in health condition.

During an interview with the Administrator and DOC #105, they confirmed that the CI report had not been amended with the information that had been requested by the Director. [s. 107. (4) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On a particular day, Inspector #613 observed the medication storage room on third floor Apple Orchard unit with RPN #112. The RPN stated that the controlled substance (Ativan injectable) was secured within the medication storage fridge via a single lock.

The Inspector also observed the Ativan injectable locked within the medication storage room fridge via a single lock.

A review of the home's policy titled, "Storage of Monitored Medications" last revised February 2017 indicated that to store controlled substances, they were to be separated from other medications, in a locked compartment of the locked cart in a locked room, while surplus controlled substances were to be stored and double locked in a separate area within the locked medication room.

During an interview with DOC #106, they confirmed that the controlled substance (Ativan injectable) that was being stored in the fridge were not double locked within the locked medication room. [s. 129. (1) (a)]

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.