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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 1, 2019	2019_776613_0007	004281-18, 006042-18, 006908-18, 007529-18, 007699-18, 007949-18, 011685-18, 025599-18, 028823-18, 029061-18, 031665-18, 032905-18, 033003-18, 033444-18, 000131-19	Critical Incident System

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East 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

LISA MOORE (613), 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): January 21 - 25, 2018.

The following intakes were inspected during this Inspection:

Eight Critical Incident reports that were submitted to the Director regarding falls resulting in an injuries and transfers to the hospital;

Two Critical Incident reports that were submitted to the Director regarding acute respiratory outbreaks;

Two Critical Incident reports that were submitted to the Director regarding alleged staff to resident verbal abuse;

One Critical Incident report that was submitted to the Director regarding resident to resident physical abuse;

One Critical Incident report that was submitted to the Director regarding injury sustained during the provisions of care;

A concurrent Complaint Inspection #2019_776613_0006, was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Executive Director of Care (EDOC), Directors of Care (DOCs), Infection Control Lead Registered Practical Nurse (IC RPN), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, human resource files and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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).

Findings/Faits saillants :

1. The license 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 #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying that resident #009 received an injury during care. The CI report identified that PSW #101 was providing a specific intervention to resident #009 in their bed; after providing the specific intervention to the resident, PSW #101 noticed that resident #001 had an injury.

A review of the resident's care plan identified that extensive total assistance by two staff members was required when providing a specific intervention to the resident in their bed.

During an interview with PSW #101, they stated that they were providing care without the assistance of another staff member and they should not have done it by themselves. The PSW further stated there should have been two staff members to provide care, as resident #009's care plan stated two people were required.

During an interview with Director of Care (DOC) #119, they stated that PSW #101 had not followed resident #009's care plan and provided care alone and should have called another PSW to assist them with the resident's care.

2. Inspector #542 reviewed a CI report that was submitted to the Director, identifying that resident #004 had a fall which resulted in a significant change in their health status. Resident #004 was transferred to the hospital, where it was determined that they had sustained an injury. It was documented in the CI report that a falls prevention intervention had not been implemented.

A review of the resident's progress notes identified that resident #004 had attempted to self-transfer into their bed and had fallen. The progress not also identified that a falls prevention intervention was not initiated.

A review of the care plan, active at the time of the incident, indicated that the staff were to ensure that an intervention was initiated and working effectively to prevent risk of falls.

A review of the home's investigation file indicated that PSW #106 failed to ensure that the resident's falls intervention was initiated. PSW #106 was disciplined for failing to follow the plan of care for resident #004 and placing the resident at risk of injury.

3. Inspector #542 reviewed a CI report was submitted to the Director, identifying resident #005 had a fall that resulted in an injury. It was further documented that PSW #107

admitted to not following the resident's care plan by not initiating a specific intervention before leaving resident #005's room.

A review of the resident's active care plan, at the time of the incident, indicated that resident #005 was to have a specific intervention initiated.

A review of the home's investigation file identified that PSW #107 received discipline for not following the care plan for resident #005.

4. On January 23, 2018, Inspector #542 observed resident #019 sitting in a common area. The resident was noted to have a specific intervention , which did not appear to be initiated.

During an interview with PSW #104, they indicated that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #019 was to have a specific intervention initiated.

5. Inspector #542 observed resident #020 to have a specific intervention which did not appear to be activated.

During an interview with RPN #105, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #020 was to have a specific intervention initiated.

6. Inspector #542 observed resident #021 sitting in a common area. The resident was noted to have a specific intervention that did not appear to be initiated. A PSW student was observed to approach the resident and initiate the intervention.

A review of the resident's current care plan indicated that resident #021 was to have a specific intervention initiated.

7. Inspector #542 observed resident #022 to have a specific intervention that did not appear to be initiated.

During an interview with PSW #117, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #022 was to have a specific intervention initiated.

8. Inspector #542 observed resident #023 to have a specific intervention that did not appear to be initiated.

During an interview with PSW #118, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #023 was to have a specific intervention initiated.

During an interview with DOC #120, they stated that staff were to follow the residents' plan of care and ensure specific interventions were initiated. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

Inspector #613 reviewed a letter of complaint that the home had received and submitted to the Director, dated on a specific date in September 2018. The correspondence detailed concerns from a complainant related to the absence of notification of a resident's health status. The letter identified that the home had acknowledged the written email and would be completing a review of the concerns and that a written response would be provided within 10 days.

A review of the home's investigation file regarding the written complaint revealed that a response letter was sent to the complainant and the Director on a specific date in September 2018, which identified that the home had completed a review of the concerns and would be able to provide further details and explanation of the internal process and findings on an onsite meeting on a specific date in October 2018. There was no written response letter in the home's investigation file.

A review of the home's policy titled,"Complaints and Customer Service, RC-09-01-04," last revised on April 2017, identified that the Administrator/Designate or Department Manager/Designate would provide a written response at conclusion of their investigation, which would include what the home had done to resolve the complaint and this would be shared with the complainant. A disclosure meeting could be required and a written response was to be provided to the complainant at the meeting.

The Inspector reviewed another letter of compliant that the home had submitted to the Director on a specific date in April 2018, by the same family member, regarding care issues. A review of the home's investigation file to this written compliant identified that the home had acknowledged receipt of the written email, would be completing a review of the concerns, and that a written response would be provided within 10 days. There was no written response letter in the home's investigation file.

During an interview with the Administrator, they stated that they had not provided a written response letter to the complainant for the September 2018 written complaint, but rather had a meeting with the complainant in October 2018, where the concerns were resolved. The ADM stated they were unable to locate a written response for the April

2018 written complaint. The ADM confirmed that written responses had not been provided to the complainant. [s. 101. (1) 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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately, to be implemented voluntarily.

Issued on this 13th day of February, 2019

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2019_776613_0007
Log No. / No de registre :	004281-18, 006042-18, 006908-18, 007529-18, 007699-18, 007949-18, 011685-18, 025599-18, 028823-18, 029061-18, 031665-18, 032905-18, 033003-18, 033444-18, 000131-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 1, 2019
Licensee / Titulaire de permis :	F. J. Davey Home 733 Third Line East, 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 :	Barbara Harten

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

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

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. (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 must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

A) Ensure two staff members provide resident #009's care, as specified in their plan of care;

B) Ensure residents' #004, #019, #020, #021, #022 and #023's falls prevention interventions are initiated, as specified in their plans of care;

C) Ensure resident #005's falls prevention intervention is initiated, as specified in their plan of care.

Grounds / Motifs :

1. The license 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 #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying that resident #009 received an injury during care. The CI report identified that PSW #101 was providing a specific intervention to resident #009 in their bed; after providing the specific intervention to the resident, PSW #101 noticed that resident #001 had an injury.

A review of the resident's care plan identified that extensive total assistance by two staff members was required when providing a specific intervention to the resident in their bed.

During an interview with PSW #101, they stated that they were providing care without the assistance of another staff member and they should not have done it by themselves. The PSW further stated there should have been two staff members to provide care, as resident #009's care plan stated two people were required.

During an interview with Director of Care (DOC) #119, they stated that PSW #101 had not followed resident #009's care plan and provided care alone and should have called another PSW to assist them with the resident's care.

2. Inspector #542 reviewed a CI report that was submitted to the Director, identifying that resident #004 had a fall which resulted in a significant change in their health status. Resident #004 was transferred to the hospital, where it was determined that they had sustained an injury. It was documented in the CI report that a falls prevention intervention had not been implemented.

A review of the resident's progress notes identified that resident #004 had attempted to self-transfer into their bed and had fallen. The progress not also identified that a falls prevention intervention was not initiated.

A review of the care plan, active at the time of the incident, indicated that the staff were to ensure that an intervention was initiated and working effectively to prevent risk of falls.

A review of the home's investigation file indicated that PSW #106 failed to ensure that the resident's falls intervention was initiated. PSW #106 was disciplined for failing to follow the plan of care for resident #004 and placing the resident at risk of injury.

3. Inspector #542 reviewed a CI report was submitted to the Director, identifying resident #005 had a fall that resulted in an injury. It was further documented that PSW #107 admitted to not following the resident's care plan by not initiating a specific intervention before leaving resident #005's room.

A review of the resident's active care plan, at the time of the incident, indicated that resident #005 was to have a specific intervention initiated.

A review of the home's investigation file identified that PSW #107 received discipline for not following the care plan for resident #005.

4. On January 23, 2018, Inspector #542 observed resident #019 sitting in a common area. The resident was noted to have a specific intervention , which did not appear to be initiated.

During an interview with PSW #104, they indicated that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #019 was to have a specific intervention initiated.

5. Inspector #542 observed resident #020 to have a specific intervention which did not appear to be activated.

During an interview with RPN #105, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #020 was to have a specific intervention initiated.

6. Inspector #542 observed resident #021 sitting in a common area. The resident was noted to have a specific intervention that did not appear to be initiated. A PSW student was observed to approach the resident and initiate the intervention.

A review of the resident's current care plan indicated that resident #021 was to have a specific intervention initiated.

7. Inspector #542 observed resident #022 to have a specific intervention that did not appear to be initiated.

During an interview with PSW #117, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #022 was to

have a specific intervention initiated.

8. Inspector #542 observed resident #023 to have a specific intervention that did not appear to be initiated.

During an interview with PSW #118, they verified that the intervention was not initiated and that it should have been.

A review of the resident's current care plan identified that resident #023 was to have a specific intervention initiated.

During an interview with DOC #120, they stated that staff were to follow the residents' plan of care and ensure specific interventions were initiated.

The severity of this issue was determined to be a level 3, as actual harm or risk to the residents did occur. The scope of this issue was a level 3, as it was wide spread throughout the home. The home had a level 4 compliance history, as there was on-going non-compliance with this section of the LTCHA that included:

-Voluntary Plan of Correction (VPC) issued March 13, 2018 (2018_671684_0007);

-Voluntary Plan of Correction (VPC) issued February 7, 2017 (2016_336620_0023);

-Voluntary Plan of Correction (VPC) issued September 22, 2016 (2016_283542_0003).

(613)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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