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

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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_0006	009374-18, 020407-18, 027335-18, 000575-19	Complaint

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), AMY GEAUVREAU (642)

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): January 21 - 25, 2019.

The following complaints were inspected during this inspection:

Two Complaints that were submitted to the Director regarding bruising of unknown origin;

One Complaint that was submitted to the Director regarding the discharge of a resident and the provisions of care;

One Complaint submitted to the Director regarding the provisions of care.

A concurrent Critical Incident System Inspection #2019_776613_0007 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), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario Registered Personal Support Worker (BSO PSW), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) 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 licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Skin and Wound Care

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

2 WN(s)
2 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	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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director, which identified concerns regarding resident #016, who had been brought to a common area, without their prescribed intervention, even when the resident had requested it. The complainant was concerned, as they had observed the resident without their prescribed intervention on numerous occasions, even though they had placed signs up in the resident's room to always have their prescribed intervention, due to the resident's health conditions.

Inspector #642 reviewed resident #016's admission medical orders dated in May 2018. The document indicated that the prescribed intervention was to be administered in a specified manner.

A review of the resident's care plan, included an intervention dated on a specific date in 2018, "administer prescribed intervention as ordered. Refer to Medication Administration Record (MAR)."

A review of the resident's progress notes, identified a note created by RPN #103, which stated that the resident had been brought to the common area by PSW #110, without their prescribed intervention, even though the resident had requested it. The RPN noticed the resident in the common area without their prescribed intervention and advised the PSW that resident #016 required their prescribed intervention, at all times.

During interviews with RN #107, RPN #103 and PSW #105, they stated that all staff were supposed to follow the resident's plan of care.

During an interview with DOC #120, they stated that PSW #110 should have applied the resident's prescribed intervention, as requested by the resident, and followed the resident's plan of care.

The licensee failed to ensure that resident #016's prescribed intervention was administered to them in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under section, 145 (1), the licensee shall, in collaboration with the appropriate placement coordinator and other health services organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

A complaint was submitted to the Director, which outlined concerns that the home had discharged resident #015 to the hospital on a specific date, due to escalation of their responsive behaviors. The complainant reported that there was no collaboration or discharge planning for the resident and the family had been told that the resident could not return to the home.

Inspector #642 reviewed the resident's progress notes, which revealed that there was no documentation regarding the discharge planning of resident #015. After review of the census information, the Inspector identified that resident #015 was transferred to the hospital and discharged on a specific date.

A review of resident #015's closed medical file, included a discharge letter dated on a specific date, addressed to the resident's substitute decision-maker (SDM). The letter stated the resident had been declined to return to the home related to the incident that had occurred on a specific date and was confirming discharge of resident #015.

A review of the home's policy titled, "Discharge," revised April, 2017, identified that the home would make every effort to ensure that every resident transferred and discharged from any of their homes was done in a well-planned and coordinated manner in order to: achieve continuity of care, reduce the anxiety to the resident and the family related to the transfer or discharge, provide the receiving unit or facility with appropriate documentation, develop a comprehensive discharge plan which considered the resident's need, safety and preferences.

Inspector #642 interviewed the Manager of Patient Flow from the hospital, where the resident was transferred on a specific date, after the incident. They stated that the home had discharged resident #015 without any discharge planning and the home did not want to discuss the discharge, "they just did it."

During an interview with Director of Care (DOC) #120, they stated that the day resident #015 was sent to hospital was the day they were discharged. DOC #120 further stated they were aware they did not follow the home's discharge policy. When asked when the resident was discharged, DOC #120 stated, when the police took the resident to the hospital.

During an interview with the Administrator (ADM) and the Executive Director of Care (EDOC), they stated that the home had not done any discharge planning for resident #015, when the resident was transferred to the hospital on a specific date. They further

stated that was the day the resident was discharged, and stated that this was not a typical discharge; therefore, the resident's SDM was not notified. The hospital was not consulted or the outside sources which would have considered the resident's needs, safety and preferences for discharge planning. [s. 148. (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 before discharging a resident under section, 145 (1), the licensee shall, in collaboration with the appropriate placement coordinator and other health services organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident, 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.