Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 18, 19, 20, 21, Nov 1, 8, 2011	2011_099188_0023	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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with CEO/Administrator, Executive Manager of Nursing Services, Directors of Nursing, Registered Nursing Staff, Personal Support Workers, Residents and Families.

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

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Medication

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed a Mandatory Report. Inspector noted the incident of abuse was reported to the Director outside of the immediate reporting time frame. The licensee failed to ensure the Director was immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(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 the Director is immediately notified of abuse of a resident by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Inspector reviewed a Mandatory Report. Inspector noted that it identifies an incident of abuse. Inspector noted that the substitute decision maker for the victim was not notified within 12 hours of the licensee becoming aware of the allegations. The licensee failed to ensure that a resident's substitute decision maker is notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed abuse of the resident. [O.Reg. 79/10 s.97(1)(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 ensuring resident's substitute decision-makers are notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed abuse of the resident, to be implemented voluntarily.

WN #3: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. Inspector noted this resident's care needs changed. Inspector reviewed the plan of care for this resident and noted that this resident's change in care needs was not identified. The licensee failed to ensure the resident is reassessed and the plan of care reviewed when the resident's care needs change. [LTCHA 2007, S.O. c.8, s.6(10)(b)]
2. Inspector reviewed the plan of care for a resident. Inspector noted that the care plan for this resident includes specific interventions related to responsive behaviours. Inspector spoke with two staff members on the unit which this resident resides, neither staff member were aware that this resident required interventions related to the responsive behaviour. Both staff members identified these interventions were not being followed. The licensee failed to ensure that staff are kept aware of the contents of the plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(8)]
3. Inspector reviewed the plan of care for a resident. Inspector noted that the care plan identifies an intervention related to a responsive behaviour. This intervention does not provide clear direction to staff and others who provide direct care to the resident on how often to implement this intervention. There is no further direction in the plan of care identifying how often to implement this intervention. The licensee failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. c.8, s.6(1)(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 the plan of care provides clear direction to staff and that staff are aware the contents of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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. Inspector reviewed the health care record, including Medication Administration Record (MAR) and physician's orders for a resident. Inspector noted that the physician's order for a medication provided different directions for use than what was identified in the MAR for that resident. Inspector noted that the medication was administered according to the directions identified in the MAR and not the directions for use specified by the prescriber. The licensee failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber. [O.Reg. 79/10, 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 ensuring drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Inspector spoke with the CEO/Administrator and the Executive Director of Nursing Services. Inspector was informed that there is currently a policy related to complaints and that a revised policy will soon be implemented. Inspector inquired related to several written and verbal complaints that were brought to the inspector's attention that had been brought forward to the home's administration. It was identified that responses were provided to the complaints; however a documented record of these complaints which meets the requirements was not available. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution and any response provided to the complainant and the complainant's response. [O.Reg. 79/10, s.101(2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Inspector noted several emailed complaints that had been sent to the administration of the home. Inspector noted these written complaints concerning the care of residents were not forwarded to the Director. The licensee failed to ensure that written complaints concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director. [LTCHA 2007, S.O. 2007, c.8, s.22(1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. Inspector identified that a dependent resident did not have access to the resident-staff communication system while in bed. The licensee failed to ensure that this resident was able to access the resident-staff communication and response system at all times. [O.Reg. 79/10, s.17(1)(a)]
2. Inspector identified that a dependent resident did not have access to the resident-staff communication system while in bed. The licensee failed to ensure that this resident was able to access the resident-staff communication and response system at all times. [O.Reg. 79/10, s.17(1)(a)]

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 ensure all residents have access to the resident-staff communication system at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector identified that a resident who requires staff assistance to maintain continence was not provided assistance and the resident was incontinent. The licensee failed to ensure that residents who are unable to toilet independently some or all of the time receive staff assistance to manage and maintain continence. [O.Reg. 79/10, s.51(2)(c)]

WN #9: 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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents titled "Resident Abuse". This policy does not include an explanation of the duty under section 24 of the Act to make mandatory reports. This policy identifies that staff will be made aware of the action that will be taken but fails to set out what the consequences for those who abuse or neglect residents are. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty to make mandatory reports and the consequences for those who abuse or neglect residents. [LTCHA 2007, S.O. 2007, c.8, s.20(2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents titled "Resident Abuse". This policy does include that staff will be orientated and re-trained but fails to include, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff. [O. Reg. 79/10, s.96(e)]
2. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents titled "Resident Abuse". This policy identifies "family representative will be notified" but fails to include that the family will be immediately notified of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in physical injury or pain to the resident and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The written policy fails to identify that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation, immediately upon the completion of the investigation. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents identifies who will be informed of the investigation. [O. Reg. 79/10, s.96(d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted this report identifies an incident when one resident displayed inappropriate behaviours towards a second resident. Interventions were identified to ensure the safety of both residents. Inspector noted that these interventions were not being followed. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by failing to implement the identified interventions. [O.Reg. 79/10, s.54(b)]

Issued on this 8th day of November, 2011

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