



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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*

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*

**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**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : DIANA STENLUND (163)

Inspection No. /

No de l'inspection : 2013_139163_0005

Log No. /

Registre no: 1357-12, 11-13

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : May 6, 2013

Licensee /

Titulaire de permis : F. J. DAVEY HOME
733 Third Line East, Box 9600, 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 :** PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s)
by the date(s) set out below:



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Order # / **Order Type /**
Ordre no : 001 **Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #007;
2012_099188_0015, CO #001;

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 shall ensure that for residents #1113 and #1357, who are at high risk for falls, the care set out in their plans of care is provided as specified in their plans.

Grounds / Motifs :



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1. Twelve previous written notifications of non-compliance under LTCHA s.6 have been issued, including one voluntary plan of correction (VPC) issued in October 2011 during inspection #2011_099188_0023 and four compliance orders (COs) issued in: December 2011 during inspection #2011099_0034, February 2012 during inspection #2012_099188_0005, April 2012 during inspection #2012_099188_0015, and in April 2013 during inspection #2012_104196_0033. A CO was issued in July 2012 during inspection #2012_099188_0027 where a Director's Referral (DR) followed.

Inspector reviewed the health care record for resident # 1113 who is at high risk for falls. Inspector noted that this resident was not wearing proper foot wear on two occasions where falls occurred. This is contrary to the resident's plan of care requiring proper foot wear. An additional fall was noted where the resident had removed the clip for the Posey bed alarm and got out of bed and fell. The resident was sent to hospital with a diagnosis of a left hip fracture. The inspector noted that the resident's plan of care requires that the bed alarm is to be clipped to the resident when in bed. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. (163)

2. Inspector reviewed the health care record for resident # 1357 who is at high risk for falls. It was noted by the inspector that a fall was documented, whereby the resident was not wearing non-slip shoes at the time of the fall, as required, in the resident's plan of care. Inspector noted another fall resulting in a hip fracture, where the resident was not wearing hip protectors as required in their plan of care. The inspector observed resident #1357 with their call bell at the head of the bed and not pinned to the resident as required in the resident's plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. (163)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 17, 2013



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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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
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.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of May, 2013

Signature of Inspector /
Signature de l'inspecteur : *Diana Stenlund, #163*

Name of Inspector /
Nom de l'inspecteur : DIANA STENLUND

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2013	2013_139163_0005	1357-12, 11- 13	Critical Incident System

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

DIANA STENLUND (163)

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): Feb 19-20, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Nursing Services, Directors of Nursing, registered nursing staff, personal support workers, and residents.

During the course of the inspection, the inspector(s) reviewed health care records, observed staff to resident interactions and care, and reviewed critical incident documentation.

**The following Inspection Protocols were used during this inspection:
Falls Prevention**

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. Inspector reviewed the health care record for resident #1357 who is at high risk for falls. It was noted by the inspector that a fall was documented, whereby the resident was not wearing non-slip shoes at the time of the fall, as required, in the resident's plan of care. Inspector noted another fall resulting in a hip fracture, where the resident was not wearing hip protectors as required in their plan of care. The inspector observed resident #1357 with their call bell at the head of the bed and not pinned to the resident as required in the resident's plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

2. Inspector reviewed the health care record for resident #1113 who is at high risk for falls. Inspector noted that this resident was not wearing proper foot wear on two occasions where falls occurred. This is contrary to the resident's plan of care requiring proper foot wear. An additional fall was noted where the resident had removed the clip for the Posey bed alarm and got out of bed and fell. The resident was sent to hospital with a diagnosis of a left hip fracture. The inspector noted that the resident's plan of care requires that the bed alarm is to be clipped to the resident when in bed. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 6th day of May, 2013

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

Diana Jenlund, #163