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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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	_ Licensee Copy/Copie du Titulaire X **Public Copy/Copie Public**	
Date(s) of inspection/Date de l'inspection November 23 – 26, 2010	**Inspection No/ d'inspection** **2010_106_2936_23Nov115130**	**Type of Inspection/Genre d'inspection** Mandatory Report Inspection

Licensee/Titulaire
F. J. Davey Home, 733 Third line Road, Box 9600, Sault Ste Marie, ON, P7A 7C1
Fax: 705-942-2234

Long-Term Care Home/Foyer de soins de longue durée
F. J. Davey Home
Fax:705-256-4207

Name of Inspector(s)/Nom de l'inspecteur(s)

Margot Burns-Prouty #106

Gail Peplinskie #154

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Mandatory Report inspection.

During the course of the inspection, the inspector(s) spoke with: The Administrator, the Executive Director, Director of Nursing, RAI Coordinator, Registered Nurse, Registered Practical Nurse, and Personal Support Workers.

During the course of the inspection, the inspector(s): Interviewed staff members, observed care provided to residents in facility, audited electronic plan of care, audited written plan of care, reviewed facility policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection: Skin and Wound Care

☐ There are no findings of Non-Compliance as a result of this inspection.

X Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with [LTCHA, 2007, S. O. 2007, C8, 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: This was found not to be in compliance.

The care set out in the plan of care, was not provided to the resident as specified in the plan on November 24, 2010.

1. A resident's plan of care states, "Ensure that glasses are on and are clean each morning" this resident was not wearing glasses when observed from 1415 to 1650 on November 24, 2010.

2. A resident's plan of care states "gets up for only 3 hrs at a time…" This resident was observed to be up in their chair from 1415 to 1650 on November 24, 2010. Two direct care staff members from the resident home area were asked when the resident was put into their chair. Both staff members told the inspector that they did not know exactly when the resident was placed into their chair as they began their shift at 1400 and the resident was already in the lounge. At 1650, the resident was placed at the dining room table awaiting their supper meal.

3. On November 24, 2010, a resident was observed to have a table top device while in their chair from 1415 to 1650. The written plan of care for this resident does not address the use of a table top device while up in their wheelchair.

4. Review of a critical incident report submitted to the Ministry and a resident's nursing progress notes show that on August 20, 2010 the written plan of care was not followed when their wound dressing was not changed according to the plan.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, S. 50(2)(d):

Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Findings: This was found not to be in compliance.

A resident who is dependent on staff for repositioning was not repositioned on November 24, 2010, from 1415 to 1650, when they were observed sitting in their wheelchair.

Two direct care staff members from the resident home area were asked when the resident was put into their wheelchair. Both staff members told the inspector that they did not know exactly when the resident was placed into their chair as they began their shift at 1400 and the resident was already in the lounge, in their wheelchair.

Inspector ID #:	106 & 154

WN #3: The Licensee has failed to comply with O. Reg. 79/10, S. 73(1)4:

Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Monitoring of all residents during meals.

Findings: This was found not to be in compliance.

The licensee did not ensure that all residents were monitored during the breakfast meal service on November 25, 2010.

Four residents were in the dining room with food and/or fluids in a resident home area dining room at the end of the Breakfast service with no supervision. One resident was actively eating, another resident was not actively eating but had their meal on the table in front of them and the other residents had fluids in front of them.

When a direct care staff member came into the dining room she was asked who was monitoring the residents left in the dining room she stated she was, but she had just left for a minute, to porter a resident to their room. She then left taking another resident back to their room, leaving the remaining residents unsupervised.

Inspector ID #:	106 &154

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title:	**Date:**	**Date of Report (if different from date(s) of inspection).** December 23, 2010