Ontario

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 **August 16-19, 2010**	**Inspection No/ d'inspection** 2010_106_2936_17Aug152407	**Type of Inspection/Genre d'inspection** Complaint

Licensee/Titulaire
F. J. Davey Home

Long-Term Care Home/Foyer de soins de longue durée
F. J. Davey Home

Name of Inspector(s)/Nom de l'inspecteur(s)
Margot Burns-Prouty (ID#106)

Inspection Summary/Sommaire d'inspection

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

This inspection was completed concurrently with two other inspections during the course of all three inspections the inspector spoke with: the Executive Director, RAI Coordinator, Registered Nurse, Registered Practical Nurse, and Personal Support Workers.

This inspection was completed concurrently with two other inspections during the course of all three inspections the inspector: 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:
-Safe and secure Home, Personal Support Services and Responsive Behaviours.

☐ 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:

6 WN
0 VPC
0 CO: CO #
0 WAO: WAO #
0 DR

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, C. 8, S. 5**:

Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings: This was found not to be in compliance.

A safe and secure environment was not provided for a resident. The resident was able to elope from the secure special care unit to the parking lot where they sustained injuries. This confused resident traveled through 2 doors that are locked and required a keypad code to open. Progress notes indicate staff on the unit was not aware resident was missing until the charge nurse contacted the resident home area to report resident was in front parking lot and fell.

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WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, C. 8, S. 6(10)(b):**

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, the resident's care needs change or care set out in the plan is no longer necessary;

Findings: This was found not to be in compliance.

1. A resident eloped from special care unit. Resident's plan of care as of August 18, 2010, did not include any interventions that indicated that resident is at risk of elopement.

2. A resident has not been reassessed and his plan of care has not been reviewed since a significant change in status. Progress note documentation in August, 2010 indicate that a resident was moved to third floor special care unit because of a significant change in status and a need for increased monitoring. Last assessments entered into RAI MDS regarding this resident are dated June 1, 2010.

3. A resident currently resides in a home area that written plan of care states they are restricted from. Resident transferred to the home area in August and the audit of their written plan of care was completed ten days after the transfer.	
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WN #3: The Licensee has failed to comply with **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).	
Findings: This was found not to be in compliance. The care set out in the plan of care is not being provided to a resident as specified in the plan.	
Inspector ID #:	106

WN #4: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, C. 8, 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).	
Findings: This was found not to be in compliance. During staff interview on August 19, 2010 with a HCA providing direct care to a resident, the staff member was not aware of the content of the written plan of care for this resident.	
Inspector ID #:	106

WN #5: The Licensee has failed to comply with **O. REG. 79/10, S. 107(1)4:** Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.	
Findings: This was found not to be in compliance. Resident nursing progress notes indicate that a resident was missing from third floor special care unit and returned to the home with injuries to their face, the licensee failed to report this to the director as required.	
Inspector ID #:	106

WN #6: The Licensee has failed to comply with **O. REG. 79/10, S. 107(3)4:** The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An

injury in respect of which a person is taken to hospital.
Findings: This was found not to be in compliance. Resident nursing progress notes indicate that a resident was transferred to hospital after sustaining a fall the previous day, the licensee failed to report this to the director as required.

Inspector ID #:	106

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).** August 20, 2010