



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

**Rapport d'inspection
prévus 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

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

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 23 – 26, 2010	2010_106_2936_23Nov1622	Critical Incident 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 Critical Incident 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 plans of care, audited written plans 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. ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 1 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 envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

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'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, S. 50(2)(b)(i):

Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment

Findings: This was found not to be in compliance.

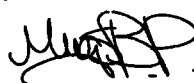
A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A review of a resident's nursing progress notes show that on July 26, 2010, an alteration in their skin integrity was found. No record of this wound being assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was found to be completed for this wound until August 12, 2010.

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