



**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

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection November 23-26, 2010	Inspection No/ d'inspection 2010_154_2936_26Nov081252	Type of Inspection/Genre d'inspection Complaint Log #S-00299 IL-NC-14392
Licensee/Titulaire F. J. Davey Home, 733 Third Line East, Box 9600, Sault Ste Marie ON P6A 7C1 Fax: 705-942-2234		
Long-Term Care Home/Foyer de soins de longue durée F. J. Davey Home, 733 Third Line East, Box 9600, Sault Ste Marie ON P6A 7C1 Fax: 705-942-2234		
Name of Inspector(s)/Nom de l'inspecteur(s) Gail Peplinskie #154 Margot Burns-Prouty #106		
Inspection Summary/Sommaire d'inspection		

The purpose of this inspection was to conduct a Complaint Inspection related to care.

During the course of the inspection, the inspector(s) spoke with:

- Administrator
- Director Of Care
- Nurse Managers
- RAI MDS Coordinator
- Registered Nursing Staff
- Personal Support Workers (PSW)
- Dietary Aides

During the course of the inspection, the inspector(s):

- reviewed the health care record for a resident
- walked throughout a specific care unit in the home
- reviewed the home's Abuse Policy and Procedure
- reviewed the home's Infection Control Policy and Procedure, specifically related to Isolation
- reviewed the home's menu for nourishments/fluids for am, pm and hs for two units of the home
- observed some care provided to a resident

The following Inspection Protocol was used during this inspection:

1. Prevention of Abuse and Neglect

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 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 LTCHA, 2007, S.O. 2007, c.8, s.19 (1): Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. The licensee did not ensure that a resident was protected from abuse by anyone. Documentation in the health care record for a resident, identified that an intervention put in place, related to managing infection control for one resident, constituted abuse.
2. Documentation in a resident's health care record identified that the resident became more agitated due to this intervention.

Inspector ID #: 154 and 106

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3 (1): Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. The licensee did not ensure that a resident's right, to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted, related to infection control intervention put in place for a resident.

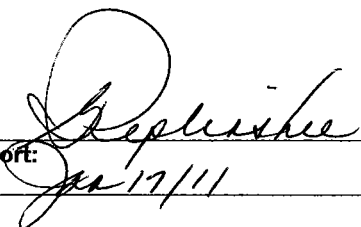
Inspector ID #: 154 and 106

WN #3: The Licensee has failed to comply with O. Reg. 79/10, 2007, s. 71(1): Every licensee of a long-term care home shall ensure that the home's menu cycle, (d) includes alternative beverage choices at meals and snacks

Findings:

1. On November 16/10 at 10:00 am, the inspector observed the nourishment cart on a care unit being passed with water in pitchers. No alternative beverage choice was observed by the inspector on the cart. The inspector asked a dietary aide about the cart and she referred to it as the "water cart". When the inspector asked if residents had an alternate beverage choice, in the morning, she stated that the residents are offered only water.

Inspector ID #: 154 and 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:




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