Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2019	2019_822613_0008	021927-19	Critical Incident System

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East 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

LISA MOORE (613)

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): December 18 - 19, 2019.

The following intake was inspected during this Inspection:

One intake that was submitted to the Director regarding a fall resulting in an injury and transfer to the hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, and the licensee's policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return from hospital.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #001 had a fall resulting in an injury and transfer to the hospital. The CI report further stated that resident #001 was admitted to the hospital with a injury on the same date and returned to the Long Term Care (LTC) Home on a specific later date.

A review of the licensee's policy titled, "Skin and Wound Program: Prevention of Skin Breakdown" (RC-06-12-10) last updated on August 2019, identified that all residents with a Pressure Ulcer Risk Scale (PURS) of greater then one would be considered at risk of altered skin integrity and receive a comprehensive head-to-toe skin assessment by a Nurse upon any return from hospital.

A review of the progress notes indicated that resident #001 was readmitted to the LTC Home on a specific date and time and that a skin assessment was completed on another date and time, more than a day later, and that they had compromised skin integrity.

During an interview with RPN #101, they stated that skin assessments were to be completed on residents the same date that they returned from the hospital. The RPN reviewed the documentation on Point Click Care (PCC) and stated that resident #001 returned from the hospital on a specific date, but the skin assessment had not been completed until more than a day later. RPN #101 stated that the skin assessment should have completed on the shift and date that resident #001 had returned from the hospital.

During an interview with DOC #100, they confirmed that skin assessments were to be completed by registered staff when a resident returned to the home after a transfer from the hospital, when it was over 24 hours. The DOC stated she was unsure why the skin assessment had not been completed for resident #001, on the date that they had returned from the hospital. [s. 50. (2) (a) (ii)]

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.