

**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 |
|--|---|-----------------------------------|--|
| Jul 9, 2020 | 2020_638542_0011 | 009581-20 | Complaint |

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

JENNIFER LAURICELLA (542), HILARY ROCK (765)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 15 - 19, 22 - 26, 29 - 30 and July 2, 2020.

The following intake was inspected on during this inspection;

One intake related to the quality of food in the home and choices not being offered.

A Follow Up Inspection #2020_638542_0013 and a Critical Incident Inspection #2020_638542_0012 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director of Care (EDOC), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietician (RD), Dietary Supervisor, the Infection Prevention and Control (IPAC) lead, Behavioural Supports Ontario (BSO) staff, Personal Support Workers (PSWs), Dietary Aides and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant home policies, and observed meal services, resident rooms, resident common areas, and the delivery of resident care, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Dining Observation

Food Quality

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

Inspector #542 reviewed the home's policy titled, "Hand Hygiene, dated October, 2019" that was provided by the Infection Prevention and Control Lead. It was documented in the policy, that staff were to perform hand hygiene; before and after contact with any resident, their body substances or items contaminated by them; before or after preparing, handling, serving or eating food; before or after feeding a resident and before putting on and after taking off gloves or other personal protective equipment.

On June 19, 2020, Inspector #542 conducted an observation of the home's dining process on a specific home area, during dinner. Inspector observed an unknown PSW staff wearing their protective mask. The PSW staff was observed touching the outside of their mask, handling soiled dishes then, providing assistance to residents without conducting any hand hygiene practices. The PSW staff member was observed throughout the meal service to be touching soiled items and then clean items without any hand hygiene.

Inspector #765 conducted an observation of the home's dining process on another home area during lunch. Inspector #765 observed three different PSW staff members, continuously touching their protective mask, pulling it away from their face, with no hand hygiene practices being conducted after. The Inspector then observed, the PSW staff, touching clean cutlery/dishes and the sandwiches for the residents without performing hand hygiene.

On June 23, 2020, Inspector #765 observed the lunch service on a different home area. Inspector #765 observed a PSW staff member, touching the front of their protective mask, pulling it away from their face, then the PSW staff member proceeded to clear the soiled dishes and then assisted a resident with cutting up their food and handing out desserts without performing hand hygiene. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative choices of entrees, vegetables and desserts at lunch and dinner.

A complaint was submitted to the Director, from an anonymous resident outlining concerns regarding food quality, food temperatures, and no alternate meals offered at lunch or dinner.

On June 18, 2020, Inspector #765 observed on a specific home area that the week at a glance was a "single choice menu" from Silver Group Purchasing that only had one meal choice at lunch during the full week and on the daily menu post.

During observations throughout the inspection, both Inspector #765 and #542 failed to observe residents being offered a choice of meal at lunches.

Both Inspectors interviewed the Dietary Manager together who stated that they only offered one dessert at dinner and only one entree, vegetable and dessert at lunch. They further indicated that they were not showing a sandwich as a choice at lunch because then what would be the point in taking away the second choice. The Dietary Manager stated that sandwiches were available just in case and they weren't being offered as a choice. The Dietary Manager indicated that in April the home started the non-select menu for both lunch and dinner. They confirmed that there were no alternative choices of entrees, vegetables and dessert at lunch and no alternative choice of dessert at dinner during the inspection. [s. 71. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were served using methods to prevent food borne illness.

A complaint was submitted to the Director, from an anonymous resident outlining concerns regarding food quality, food temperatures, and no alternate meals offered at lunch or dinner.

Inspector #765 reviewed the licensee's policy regarding "Tray Assembly and Service" policy NC-03-01-07, last updated March 2020, which was part of the licensee's nutrition care manual. The policy indicated that tray service was to be provided to those residents who were unable to go to the dining room and that desserts must be covered with lids or plastic wrap.

During a lunch observation on, June 18, 2020, on a specific home area, Inspector #765 noticed that the tarts for desserts were not covered on the cart being delivered to resident rooms.

Inspector #542 observed a dinner service on a different home area, and observed desserts, cake with icing, were uncovered on a cart going to resident rooms. At this time, Inspector #542 interviewed the Dietary Aide #119 who was serving the desserts, who stated that they typically would cover desserts but didn't for this service due to the icing on the cake.

Inspector #765 observed a specific home area's lunch service on June 23, 2020, and noticed that the desserts were not covered when they were being transported down the hallways to resident's rooms. The dessert cart was also observed being left unattended in hallway when staff member were in resident rooms.

Inspector #765 interviewed the Dietary Manager who stated that the requirement for transporting desserts to resident rooms was that all foods were to be covered using hard plastic covers, saran wrap or lids on the disposable bowls. They further indicated that there were no excuses for the desserts not being covered as the inspectors observed. [s. 72. (3) (b)]

Issued on this 9th day of July, 2020

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

Original report signed by the inspector.