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
Feb 9, 2021	2021_822613_0003	021301-20, 022601-20, 023841-20, 025765-20	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), AMY GEAUVREAU (642)

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): January 25 - 29, 2021.

The following intake was inspected during this Inspection:

Two Critical Incident reports and that were submitted to the Director regarding a resident fall resulting with an injury.

One Critical Incident report that was submitted to the Director regarding an unwitnessed incident resulting with an injury.

One Critical Incident report that was submitted to the Director regarding an allegation of staff to resident abuse.

A concurrent Follow Up Inspection #2021_822613_0001 and Complaint Inspection #2021_822613_0002 were also conducted during this inspection.

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

The Inspector(s) 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 internal investigation files, staff personal files, and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse of abuse and neglect of residents was complied with related to an incident of alleged abuse involving a resident.

A Critical Incident System (CIS) report was submitted to the Director, regarding an allegation of abuse towards a resident. The CIS report indicated that a PSW had heard the resident accusing another PSW of hurting and being mean to them during care, but had not reported the allegations of abuse until one day later to the RN Charge Nurse.

The PSW did not follow the the licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy when they failed to report the alleged abuse to the most senior Supervisor on shift at that time; therefore, putting the resident at risk of further abuse.

The Director of Care (DOC) verified that the PSW did not follow the licensee's zero tolerance of abuse policy by not reporting the allegations of abuse immediately to their Supervisor.

Sources: CIS report; the home's internal investigation notes; the licensee's Zero Tolerance of Abuse and Neglect policy; and interviews with the DOC and other staff. [s. 20. (1)]

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 their written policy to promote zero tolerance of abuse of abuse and neglect of residents is complied with related to staff immediately reporting suspected incidents of abuse to their immediate supervisor, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was submitted to the Director, regarding an allegation of abuse towards a resident. Refer to WN #1 for details. The CIS report indicated that the RN Charge Nurse reported the alleged abuse to the Administrator (ADM), who was the Manager on call.

The CIS report and the resident's progress notes did not identify that the SDM had been notified of the alleged abuse, at the time the RN Charge Nurse and the ADM had become aware. The RN did not follow the licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy when they failed to notify the SDM immediately upon becoming aware of the incident.

The DOC stated that resident's SDM had not been notified of the alleged abuse until three days after the alleged abuse had occurred and that the resident's SDM should have been notified when the RN Charge Nurse had become aware.

Sources: CIS report; the home's internal investigation notes; the licensee's Zero Tolerance of Abuse and Neglect policy; and interviews with the DOC and other staff. [s. 97. (1) (b)]

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 the resident's substitute decision-maker (SDM) is notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

Issued on this 10th day of February, 2021

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

Original report signed by the inspector.