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
Mar 22, 2022	2022_822613_0005	015229-21, 018689-21, 000524-22, 001083-22, 001899-22, 001910-22, 002397-22	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), JENNIFER LAURICELLA (542)

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): March 7-11 and 15-16, 2022.

The following intakes were inspected during this Inspection:

Three Critical Incident (CIS) reports regarding a resident fall resulting with an injury and transfer to the hospital;

Three CIS reports regarding allegations of staff to resident abuse; and,

One CIS report regarding tampering of narcotics.

A concurrent Follow Up Inspection #2022_822613_0003 and Complaint Inspection #2022_822613_0004 were also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Executive Director of Care (EDOC), Directors of Care (DOCs), 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, infection prevention and control (IPAC practices), staff to resident interactions, reviewed health care records, personnel files and various licensee's policies, procedures and programs.

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

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

- **3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity was respected and promoted.

A PSW provided care to a resident while they remained in their bed, resulting in an injury to the resident's skin. The PSW did not ask the other PSW who was present in the room to assist them with the resident's care.

A DOC indicated that the PSW did not treat the resident with respect and dignity when providing care and should have asked the other PSW for assistance.

The failure of the PSW not respecting and promoting the resident's rights resulted in actual injury and not having their needs met in an appropriate manner.

Sources: CIS report; the home' investigation notes; resident's progress notes and plan of care and interviews with DOC and other staff. [s. 3. (1) 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 resident's right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity is respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that a resident was protected from abuse by a RPN.

Physical abuse is defined within Ontario Regulation 79/10 as, the use of physical force by anyone other than a resident that causes physical injury or pain.

A resident became upset following care and displayed responsive behaviours towards a RPN. The RPN physically contacted the resident.

The home's internal investigation substantiated the abuse.

A RPN had provided improper care to a resident by confirming they had touched them inappropriately causing actual harm.

Sources: CIS report; the home' investigation notes; the licensee's Zero Tolerance of Abuse and Neglect policy; resident's plan of care and progress notes: and interviews with a DOC and other staff. [s. 19. (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 a resident is protected from abuse by a RPN, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they developed an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents.

The licensee's policy titled, "Management of Insulin, Narcotics and Controlled Drugs," identified that when two nurses were counting narcotics and controlled substances, the blister packs were to be inspected to ensure accuracy. Narcotics were to be counted at the point of administration.

A RPN observed a controlled substance blister pack had been tampered. The ordered controlled substance had been removed and replaced with another unidentified smaller medication.

The home was unable to determine who had tampered with the controlled substance or when the incident had occurred.

RPNs identified that registered nurses were required to take the blister package out of the storage bin, observe the front and back of the card to ensure accuracy and correct count when administering or counting narcotics and controlled substances. The EDOC also verified registered nurses were to ensure accuracy of each blister pack.

The failure of registered nurses not inspecting and ensuring accuracy of the controlled substance blister packs put the residents at risk of receiving the incorrect medication(s) and dosage(s)of their prescribed medication(s).

Sources: CI report; the home' investigation notes; the licensee's Management of Insulin, Narcotics and Controlled Drug policy; and interviews with EDOC and RPNs. [s. 114. (1)]

Issued on this 23rd day of March, 2022

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

Original report signed by the inspector.