Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
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Original Public Report

Report Issue Date: January 10, 2024	
Inspection Number: 2023-1420-0007	
Inspection Type: Critical Incident	
Licensee: F. J. Davey Home	
Long Term Care Home and City: F.J. Davey Home, Sault Ste. Marie	
Lead Inspector Jennifer Lauricella (542)	**Inspector Digital Signature** Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2024.01.16 14:43:46 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-15 and 18, 2023.

The following intake(s) were inspected:

- Three intakes, related to resident falls that resulted in injuries;
- One intake, related to resident to resident sexual abuse;
- One intake, related to a missing resident and
- Two intakes, related to COVID-19 outbreaks.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary:

A Critical Incident (CI) report was submitted to the Director indicating that, a resident was able to exit the home alone. A search was started and upon reviewing the video footage, the resident was observed exiting the building. The resident was located and returned to the home that same day.

For a period of approximately three hours, the resident was without the specific intervention that kept them safe in the building and no other interventions were put in place to ensure their safety.

An interview with a Director of Care (DOC) and a review of the home's investigation concluded that the staff members involved did not put any interventions in place to ensure the resident's safety.

The failure of staff not ensuring a safe and secure home for the resident put them at risk for injury, as they were able to exit the building unattended.

Sources: CI report; the home's investigation file; the residents health care record and interview with the DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the CI that was submitted to the Director for resident-resident abuse was conducted. Post the incident, two interventions were put in place to prevent the co-resident from entering the female resident's room.

During an observation, the Inspector observed the female resident in their bed without the two interventions in place to prevent the co-resident from entering the female resident's room.

An interview with a PSW revealed that the two interventions were to be in place to prevent co-residents from entering their room.

The failure to ensure that the safety interventions were followed as per the care plan placed the resident at a risk.

SOURCES: CI report; home's investigation file; the resident's health care records and interview with a PSW.

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