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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: March 25, 2024	
Inspection Number: 2024-1420-0001	
Inspection Type: Complaint Critical Incident	
Licensee: F. J. Davey Home	
Long Term Care Home and City: F.J. Davey Home, Sault Ste. Marie	
Lead Inspector Lisa Moore (613)	**Inspector Digital Signature** Lisa K Moore Digitally signed by Lisa K Moore Date: 2024.03.27 11:08:11 -04'00'
Additional Inspector(s) Christopher Amonson (721027)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11-15, 2024.

The following intake(s) were inspected:
· Intake related to concerns of an alleged missing resident.
· Intake related to concerns of the provision of care.
· Two intakes related to a resident fall resulting in an injury.
· Two intakes related to COVID-19 outbreaks.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

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
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

Rationale and Summary: A nurse reported to another nurse that a resident was on a leave of absence (LOA) from the home with their family. The nurse was later informed that the resident had not been taken out by the family and discovered that the resident had been in their room.

The home's investigation determined that a resident had remained in the home. A nurse had miscommunicated the resident name as being on a LOA and the oncoming staff failed to complete comfort rounds on the resident.

The incident resulted in moderate impact and risk, as they were unattended and did not receive their required care or safety checks.

Sources: Complainant; internal investigation file; a resident's health care record including progress notes, care, electronic medication administration record (eMAR), Health Care Aid charting record and Daily food and fluid intake record; Care and Comfort Rounds policy; and an interview with EDOC and other staff. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

The licensee has failed to make a report in writing to the Director setting a description of any residents involved in the COVID-19 outbreak.

Rationale and Summary: A COVID-19 outbreak was declared on a unit. The Director requested an amendment to the Critical Incident (CI) report to include any additional resident cases and areas affected in the home, by a specific date**.** The home did not amend the CI report with the requested information until four days after the Director's deadline request.

Sources: CIS report; and an interview with IPAC Manager. [613]

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