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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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: October 17, 2024

Inspection Number: 2024-1420-0004

Inspection Type:
Complaint
Critical Incident

Licensee: F. J. Davey Home

Long Term Care Home and City: F.J. Davey Home, Sault Ste. Marie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7-10, 2024
The inspection occurred offsite on the following date(s): October 15-16, 2024

The following intakes were inspected:

- One intake was a complaint related to the medication management of a resident;
- One intake was related to improper care of a resident by a staff member;
- One intake was related to an outbreak;
- One intake was a complaint related to the discharge and financial concerns of a resident.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

A Critical Incident (CI) report was submitted to the Director outlining that a staff member failed to implement an intervention for a resident, which resulted in the resident sustaining an injury.

Sources: CI report, A resident's care plan and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure the immediate reporting to the Director of the Improper care of a resident that resulted in harm.

A CI report was submitted to the Director a day after an incident of improper care of a resident that resulted in an injury to the resident had occurred.

Sources: CI report and interview with the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with Additional Requirement 10.2 (c) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022 revised September 2023), the licensee has failed to ensure that assistance to residents to perform hand hygiene was provided before meal service.

Sources: Observations during lunch meal service.