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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Public Report

Report Issue Date: January 14, 2025
Inspection Number: 2025-1420-0001
Inspection Type: Complaint Critical Incident
Licensee: F. J. Davey Home
Long Term Care Home and City: F.J. Davey Home, Sault Ste. Marie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6, 7, 8, 10, 2025

The following intake(s) were inspected:

- One Intake related to, a fall of a resident that resulted in an injury;
- One Intake related to, a complainant regarding the care of a resident;
- One Intake related to, an Outbreak and
- One Intake related to, resident to resident physical abuse.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, by not ensuring two staff were present while providing care.

Sources: A resident's health care record and an interview with the a Director of Care (DOC).

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the home's falls prevention and management program, which provided for strategies to reduce or mitigate falls, including the monitoring of residents, was followed for a specific resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program and ensure that it was complied with.

It was documented that an injury was observed on a resident. The resident had indicated they had a fallen. A further review revealed that the home did not complete a clinical monitoring record, a post falls assessment, nor was the resident assessed post fall for 72 hours as per the home's Falls Program policy.

Sources: A residents health care record, post falls assessments; home's incident reports and interview with the Falls Lead.