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

Public Report

Report Issue Date: May 16, 2025
Inspection Number: 2025-1420-0003
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): May 12-16, 2025.

The following intake(s) were inspected:
- Intake: related to a fall of a resident resulting in an injury.
- Intake: related to complaint concerns regarding care of a resident.
- Two Intakes: in relation to potential improper care of a resident.
- Intake: related to an outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that a resident's plan of care was updated to suit the recommendations from a physiotherapist in a timely manner.

Sources: a Resident's progress notes, care plan, investigation notes; and interviews with a Registered Practical Nurse (RPN), Physiotherapist (PT), and the Director of Care (DOC).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff utilized specific techniques when assisting a resident with a specific personal task. This incident caused a specific outcome to this resident.

Sources: a Resident's progress notes, care plan, investigation notes; and interviews with a PSW, RPN, PT, and the DOC.

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