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: December 23, 2022

Inspection Number: 2022-1420-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: F. J. Davey Home

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

Lead Inspector	**Inspector Digital Signature**
Lisa Moore (613)	Lisa K Moore Digitally signed by Lisa K Moore Date: 2023.01.19 10:48:29 -05'00'

Additional Inspector(s)
Jennifer Lauricella (542)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 14-18 and 21-22, 2022.

The following intake(s) were inspected:
- Intake related to offering immunizations,
- Two intakes related to an injury of unknown cause
- Intake related to a fall resulting in an injury
- Intake related to a missing resident
- Intake related to allegations of resident to resident abuse
- Intake related to resident to resident altercation.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1420-0001 related to O. Reg. 246/22, 102 (12) 3. inspected by Jennifer Lauricella (542)

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Infection Prevention and Control
Responsive Behaviours
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: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

Rational and Summary: A door to a non-residential area was noted to be ajar on a unit. The latch and lock on the door were broken, allowing any resident to be able to push the door open. The area was unsupervised, and several residents were in the area.

The Administrator (ADM) identified that a maintenance requisition had not been received to fix the door.

Sources: Observations on a unit; and Interview with the ADM.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 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 its residents.

Rationale and Summary: Staff was unable to locate a resident and the resident was later located in a non-residential area on the unit.

The investigation file identified that the door to the non-residential area did not lock, and that the resident had been in the area for an extended period to time before being located by staff.

The ADM verified that staff did not search the resident home area thoroughly, requiring the unit to be searched additional times before the resident was located. The ADM indicated that comfort rounds were not completed by staff as per expectations and staff should have provided a maintenance requisition to repair the latch and lock on the door of the non-residential area to ensure all resident's safety.

The failure of staff not ensuring a safe and secure home for the residents resulted in moderate risk and impact for the resident, as they were in the non-residential area for an extended period of time, before being located by staff.

Sources: CIS report; LTC home missing resident policies; internal investigation file; complaint letter and written response; Staff Education Resources; Code Yellow Mock Drill; and interviews with ADM and DOCs. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a RN immediately reported the allegations of abuse by a resident towards another resident to the Director.

Rationale and Summary: A RN was informed by a RPN of the allegations of abuse by a resident towards another. The RN did not immediately notify the Manger on-call or the Director of the Ministry of Long-Term Care. The Director of Care (DOC) did not become aware of the incident until the following shift.

The impact and risk to the residents was low when the RN did not notify the Director immediately of the abuse allegations.

Sources: CIS report; resident's health care records; LTC home's abuse policies; internal investigation file; and interview with a DOC. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that for every written complaint made to the licensee concerning the care of a resident or operation of the home that the response provided to the person who made the complaint shall include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary: A complaint was received by the Director identifying concerns regarding staff's response to an incident involving a resident. The response letter provided to the complainant by the home did not include the Ministry's toll-free telephone number and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

There was a low impact and risk to a resident for not including required information on the written response to the complainant.

Sources: Complaint and written response letters; and interview with the Administrator [613]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rational and Summary: A complainant indicated that the home had not notified them of a resident's injury with an unknown cause for an extended period of time after becoming aware.

The home's internal investigation documents confirmed that the substitute decision-maker (SDM) was not made aware of the resident's injury for an extended period of time after the injury was noticed.

A DOC confirmed that the home was to notify the SDM immediately when the injury or change in clinical condition was noted.

There was low risk and moderate impact to the resident at the time of the non-compliance as the home did not provide the SDM an opportunity to participate in the resident's plan of care related to their injury, which may have resulted in the resident being sent to the hospital more quickly.

Sources: Resident's health records; the home's internal investigation documents and interview with a DOC. [542]

WRITTEN NOTIFICATION: Standard or protocol issued by the Director not implemented

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rational and Summary: The licensee failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program and that at a minimum, Additional Precautions included point of care signage indicating the IPAC control measures in place, hand hygiene, including, but not limited to, at the four moments of hand hygiene and the proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

Inspector conducted observations on an outbreak unit in the home during a dining service. The following observations were made;

- A student was observed to be wearing their N95 mask incorrectly, exposing their nose and mouth,

- Several staff were noted to be touching the outside of their N95 masks without performing hand hygiene practices afterwards,

- A staff member was observed to leave the outbreak unit, doffing their shield and N95 mask, without performing any hand hygiene practices and,

- No additional precaution, point-of-care signage on three separate residents' doors/walls indicating that enhanced IPAC control measures were in place.

The Infection Prevention and Control (IPAC) lead indicated that the staff were to perform hand hygiene practices after touching their mask/doffing

PPE. Additionally, staff were to wear the N95 masks correctly and point-of-care signage should have been posted for the three rooms.

There was the potential for risk to the resident's health and safety at the time of the non-compliance, when the home did not ensure that routine practices and additional precautions were being followed on a COVID-19 outbreak unit.

Sources: Observations; and interviews with the IPAC lead. [542]

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