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: April 28, 2023	
Inspection Number: 2023-1420-0005	
Inspection Type: Complaint Critical Incident System	
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: 2023.05.03 10:19:45 -04'00'
Additional Inspector(s) Ryan Goodmurphy (638) Justin McAuliffe (000698)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17-20, 2023.

The following intake(s) were completed during this inspection:

- Intake related to medication management.
- Intake related to support services.
- Intake related provision of care.
- Intake related to responsive behaviours.
- Two Intakes related to falls.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary: A resident's medication was discontinued; however, their care plan was not updated to identify the discontinuation of the medication. The Registered Practical Nurse (RPN) on the unit was responsible for reviewing and updated the resident's plan of care whenever care needs changed.

There was no risk to the resident when the home failed to update the resident's plan of care when the medication was discontinued as the electronic medication administration record had been updated upon the discontinuation of the medication.

Sources: A resident's health care records including the care plan; digital prescriber's orders; clinical physician orders; electronic medication administration record; and interviews with the EDOC and a RPN. [638]

Date Remedy Implemented: April 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on

an assessment of a resident and on their needs and preferences.

Rationale and Summary: A resident's medication order was discontinued, and there was a change to their health status. The physician reordered the medication and the resident recovered and returned to their baseline status within a few days.

The home's management and nursing team failed to assess a resident's care needs and collaborate with the doctor regarding the licensee's medication policy prior to discontinuing the resident's long-term use of the medication. As a result, there was moderate risk and impact to a resident's health status.

Sources: A resident's health care record including the progress notes, electronic medication administration record; Digital Prescriber Orders; LTCH's medication policy; and interviews with a Doctor, a NP, EDOC, DOCs, RNs, RPNs and Complainant. [613]

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Rationale and Summary: Staff did not implement specific monitoring for a resident, for a time, as the staff roster had not included the identification of which staff were supposed to implement the specific monitoring.

There was moderate risk to residents when the intervention was not implemented.

Sources: HCA Sign In Sheet; Paper General Roster; resident observations; interviews with a DOC and other staff. [638]

WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the written policy for the medication management system to ensure the accurate administration of all drugs in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the developed interdisciplinary medication management system provided safe medication management and optimized effective drug therapy outcomes for residents and was complied with.

Specifically, staff did not comply with a licensee's medication policy, which indicated only Registered Nurses (RNs) were permitted to administer the medication to the residents.

Summary and Rationale: A resident's Medication Administration Record (MAR) identified that RPNs were administering a medication to a resident. The Extendicare policy identified that the medication could only be given by a RN.

The Executive Director of Care (EDOC) verified that RPNs were administering the medication to a resident and that the home's current policy required updating and was being updated at the Extendicare level.

Sources: A resident's health care record including the progress notes; digital prescriber orders; electronic medication record; LTC's medication policy; and interviews with a Doctor, a NP, EDOC, DOCs, RNs, RPNs and Complainant. [613]

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