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 21, 2023	
Inspection Number: 2023-1420-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: F. J. Davey Home	
Long Term Care Home and City: F.J. Davey Home, Sault Ste. Marie	
Lead Inspector Chad Camps (609)	**Inspector Digital Signature** Chad A Camps Digitally signed by Chad A Camps Date: 2023.05.08 08:30:14 -04'00'
Additional Inspector(s) Lauren Tenhunen (196)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s), February 27-28, March 1-3, and 6-10, 2023.

• One intake #00021320 was inspected upon during this Proactive Compliance Inspection (PCI) inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

Non-Compliance (NC) #001 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 issued by the Director with respect to infection prevention and control.

Rationale and Summary

Pursuant to the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" (the Standard) issued by the Director in April 2022, staff were to perform Hand Hygiene (HH) before applying and after removal of Personal Protective Equipment (PPE).

A Personal Support Worker (PSW) drank water after they placed their face mask below their chin within arm's distance from a resident and other staff. The PSW then then reapplied their face mask and left the area without performing HH.

The IPAC lead verified that the PSW should have performed HH after removing and/or reapplying their face mask.

The home's failure to ensure that the PSW implemented the Standard and performed HH after removing and reapplying their face mask presented moderate risk to residents due to the possible transmission of pathogens from the PSW.

Sources: Inspector's observations; The home's policy titled "Hand Hygiene" last updated January 2023; The "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" dated April 2022; "Routine Practices and Additional Precautions In All Health Care Settings", third edition Provincial Infectious Diseases Advisory Committee (PIDAC), last revised November 2012; Interviews with the IPAC lead and other staff. [609]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to implement the home's policies and procedures related to nutritional care and dietary services.

Rationale and Summary

When food temperatures taken that were outside their acceptable ranges, dietary staff were to contact the cook for assistance with re-heating or cooling the food.

The food temperatures for the pureed, second choice, minced entrée and the starch/grain were below the recommended range on a home area.

The Food Service Manager (FSM) reported that dietary staff should have followed the home's policy and contacted the cook to get assistance with re-heating the food, which did not occur.

The home's failure to ensure food temperatures were served warm enough posed a low risk to residents.

Sources: Observations of a home area lunch service; Interviews with the FSM and other staff; The home's policies titled "Temperatures of Food at Point of Service - NC-07-01-03" and "Holding and Distribution of Food - NC-07-01-02", last reviewed January 2022; and the Food Temperature Record sheet for a home area. [196]

WRITTEN NOTIFICATION: Accommodation Services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

Rationale and Summary

At the time of the inspection, bubbled-out flooring was observed in several areas of a home area.

The Assistant Environmental Services Manager (AESM) observed the area where the flooring had bubbled-out and confirmed they were aware of the issues with the flooring. The AESM further indicated that instead of replacing the entire floor, they were replacing small sections of the floor at a time due to budgetary constraints.

The home's failure to keep the floor in good repair posed a moderate risk to the residents that ambulated in the corridor as it was a trip hazard.

Sources: Observations of a home area; Interviews with the AESM and other staff; Review of the home's policies titled, "F. J. Davey Home - Facility Interior - M-01-03" and "Extendicare Remedial (Demand) Maintenance Program - MN-03-01-01", last reviewed January 2022. [196]

WRITTEN NOTIFICATION: Powers of Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)

The licensee has failed to ensure that they responded in writing to the Family Council (FC) within 10 days of receiving concerns or recommendations about the operation of the home.

Rationale and Summary

During a FC meeting, concerns were identified regarding the care of residents and the operation of the home.

The home's Social Worker (SW) who acted as assistant to the FC stated that the process for dealing with FC concerns was unclear.

Only after the Inspector identified the need to respond in writing to FC concerns did the SW develop a process to track FC concerns to make sure the FC received a written response within 10 days.

The Executive Director (ED) verified that they had not responded in writing, within 10 days of the FC concerns from the FC meeting.

The home's failure to respond to the FC in writing within 10 days of receiving concerns about the operation of the home presented low risk to residents.

Sources: FC meeting minutes; The "resident/family council meeting minutes concerns/suggestions" form; Interviews with the SW; and ED. [609]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applied to the home was carried out.

Rationale and Summary

Pursuant to Minister's Directive "COVID-19 response measures for long-term care homes", the licensee was required to follow the "COVID-19 guidance document for long-term care homes in Ontario", which required all staff wear a medical mask for the entire duration of their indoor shift.

The Inspectors observed Housekeeping, DA and PSW staff with their masks below their noses and a Registered Practical Nurse (RPN) with their mask under their chin, while on resident home areas.

The IPAC lead verified that when staff wore a mask, it should be over their nose and mouth.

The home's failure to ensure that all staff adhered to the Minister's Directive and wore their masks properly presented moderate risk to residents due to the possible transmission of pathogens by the staff.

Sources: Inspectors observations; "Minister's Directive: COVID-19 response measures for long-term care homes" effective August 30, 2022; "COVID-19 guidance document for long-term care homes in Ontario" updated December 23, 2022; The home's policy titled "COVID-19 Universal PPE Strategy" last reviewed November 29, 2022; Interviews with the IPAC lead and other staff. [609]

WRITTEN NOTIFICATION: Doors in the home

NC #006 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 kept closed and locked when they were not being supervised by staff.

Rationale and Summary

During the inspection, the door to a laundry chute was found unlocked and unsupervised by staff. Multiple times, a soiled utility room and clean utility room were found unlocked and unsupervised. Inside the soiled utility room chemicals were found on the counter and in an unlocked cupboard.

The Director of Environmental Services (DES) acknowledged to the Inspector that "All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents".

The home's failure to ensure the doors to the utility rooms and laundry chute were locked at all times when not supervised by staff, posed a moderate risk to residents, as they could gain access to cleaning and disinfecting supplies.

Sources: Inspector's observations; The home's policy titled "Door Security - M-01-17"; Interviews with the DES and other staff. [Inspector #196's [196]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee has failed to ensure that the home's Continuous Quality Improvement (CQI) committee contained one member from the home's Residents' Council (RC).

Rationale and Summary

During the home's CQI meeting, no member of the RC was present.

The CQI lead verified that after two years in the role, no member of the RC had been on the committee, nor had the home made any request to the RC for a member to join the committee.

The home's failure to include a member of the RC on the CQI committee presented low risk to the residents.

Sources: The home's CQI Meeting Minutes dated February 23, 2023; The home's policy titled "CQI Committee OP-02-01-15", last updated September 2022; Interview with the CQI lead. [609]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.

The licensee has failed to ensure that the home's CQI committee contained one member from the home's Family Council (FC).

Rationale and Summary

During the home's CQI meeting, no member of the FC was present.

The CQI lead verified that after two years in the role, no member of the FC had been on the committee, nor had the home made any request to the FC for a member to join the committee.

The home's failure to include a member of the FC on the CQI committee presented low risk to the residents.

Sources: The home's CQI Meeting Minutes dated February 23, 2023; The home's policy titled "CQI Committee OP-02-01-15" last updated September 2022; Interview with the CQI lead. [609]

WRITTEN NOTIFICATION: Training and orientation program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (2)

The licensee has failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary

For each of the home's programs related to skin, falls and pain, records identified staff who had not completed the training in 2022.

The home was unable to produce any policy, program or evaluation of the training and orientation program for 2022.

The Executive Director (ED) described the training and orientation program as "informal" and that there was no written policy, procedure or evaluation of the training and orientation program for the home.

The home's failure to ensure that the training and orientation program was evaluated at least annually presented moderate risk to residents cared for by staff managed by an ineffective training and orientation program.

Sources: Training records for Skin and Wound Care; Falls Prevention; Pain Management; Interviews with the ED. [609]

WRITTEN NOTIFICATION: Designated Lead

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 258

The licensee has failed to ensure that there was a designated lead for the training and orientation program.

Rationale and Summary

At the time of the inspection, the home was unable to provide documentation outlining the roles and responsibilities of the training and orientation lead nor were they certain who the lead of the program was.

The ED verified that they were aware that for all of 2022, the home did not have a training and orientation lead.

The home's failure to ensure that there was a designated lead for the training and orientation program presented moderate risk to residents cared for by staff who could be without required/up-to-date training.

Sources: Interviews with the IPAC lead; and ED. [609]

COMPLIANCE ORDER (CO) #001 Skin and wound care

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop and implement a process to ensure that skin and wound care supplies are readily available within the home. Documentation of the established process, including which team members participated in developing the process, must be maintained.

b) Review and update the home's policy titled "Skin and Wound Program: Wound Care Management" last reviewed January 2022, so that it reflects the updated process for ensuring that registered staff have ready access to required wound care supplies. Ensure that this updated process is communicated to all registered staff.

Grounds
The licensee has failed to ensure that the skin and wound care program supplies were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Rationale and Summary

a) The CQI committee identified access to adequate skin and wound care supplies as a "key issue" and that the medical directives related to wound care were not being followed as a result.

b) RN staff described the difficulties they had locating skin and wound care supplies.

As a result of lack of supplies, RPNs have been found making their own dressings out of what supplies were available.

c) The home's skin and wound policy failed to mention that residents would have ready access to supplies to treat pressure injuries, skin tears or wounds and promote healing.

d) The Executive Director of Nursing (EDOC) indicated that there was a cabinet in the nursing office which could be accessed by RNs when RPNs needed additional skin and wound care supplies.

Observations of the nursing office found no cabinet containing additional skin and wound care supplies for the RNs and/or RPNs to access.

An RN who was present in the nursing office, indicated that if an RPN required additional skin and wound care supplies, the RPN should have filled out the supply sheet and to put gauze over the wound until more supplies arrived.

The home's failure to ensure that the skin and wound care program supplies were readily available at the home presented high risk of harm to residents cared for by staff without the supplies required to relieve pressure, treat pressure ulcers, skin tears or wounds and/or promote healing.

Sources: Inspector's observations; CQI Meeting minutes for February 23, 2023; The home's policy titled "Skin and Wound Program: Wound Care Management" last reviewed January 2022; Interviews with the EDOC and other staff. [609]

This order must be complied with by May 26, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.