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: July 17, 2023
Inspection Number: 2023-1420-0006
Inspection Type: 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: 2023.08.15 15:01:02 -04'00'

Additional Inspector(s): N/A

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-23 and 26, 2023.

The following intake(s) were completed during this inspection:
•Intake related to ensuring skin and wound equipment was readily available at the home;
•Intake related to a resident with an injury
•Intake related to staff to resident neglect.

Previously Issued Compliance Order(s):

The following previously issued Compliance Order(s) was found to be in compliance: Order #001 from Inspection #2023-1420-0004 related to O. Reg. 246/22, s. 55 (2) (c) inspected by Lisa Moore (613)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen, the resident was assessed using a clinical assessment tool specifically designed for falls.

Rationale and Summary: A resident had a fall and a PSW verified they had assisted the resident from the ground to a standing position, prior to being assessed and approved for transfer by a RPN.

ADOC confirmed that a PSW did not follow the licensee's policy.

The failure of a PSW moving a resident, following their fall, and not being assessed and approved for transfer by a RPN put the resident at risk of worsening their injury.

Sources: CIS report; a resident's health care record including progress notes; investigation file; home policy and interviews with ADOC. [613]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary: Staff was not aware of a resident's location until they were observed by a nurse. The resident sustained a fall resulting in an injury while unattended.

During interviews with various staff members, they all indicated they were aware of the resident's plan of care.

The failure of staff not ensuring a safe and secure home for the resident resulted in moderate risk and the impact was a sustained injury.

Sources: CIS report; the home's investigation file; the home's video surveillance; resident's health care record including care plan and progress notes and interviews with the Administrator (ADM), Executive Director of Care (EDOC) and other staff. [613]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary: A resident's substitute decision-maker (SDM) submitted a complaint regarding not being notified immediately of an

incident that had occurred with a resident, resulting in an injury.

The response letter provided by the home to the SDM indicated that a nurse had not notified a resident's SDM immediately after the incident had occurred.

The Assistant Director of Care (ADOC) confirmed that the registered staff was to notify the SDM immediately when an incident, injury or change in clinical condition was noted.

There was low risk and impact to the resident when the home did not provide the SDM an immediate opportunity to participate in the resident's plan of care related to their incident and injury.

Sources: Resident's health care record including progress notes; the home's investigation file; complaint and response letters; home's policy; and interview with ADOC. [613]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect by PSWs.

Neglect is defined within Ontario Regulation 246/22 as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

Rational and Summary: A resident did not receive care or assistance by staff for an extended period of time.

A DOC verified that care was not provided to a resident, during this time, as per expectations and the resident's care plan.

The failure of the PSWs to provide care to a resident for an extended period of time presented a moderate impact and risk to the resident.

Sources: CI report; internal investigation file; the home's policy; and interview with a DOC. [613][

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 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 the neglect of a resident that resulted in a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary: A DOC and the ADM received a complaint from a resident's SDM expressing a concern of resident neglect.

The incident was reported to the Director several days after the home received the complaint.

A DOC verified the incident was reported late.

There was no risk to the resident when the home failed to immediately report the incident to the Director.

Sources: CI report; home's policy; and interview with a DOC.[613]

WRITTEN NOTIFICATION: Air Temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure the temperature was measured under subsection (2) and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary: A review of the "Temperature Screening Logs" for a specific time frame, identified several dates that the air temperature were not taken or documented at the required times.

The Assistant Director of Environmental Services (ADES) verified that their staff had not taken the air temperatures at the required times.

The failure of staff not measuring and documenting the room temperatures put the residents at risk for heat related illnesses.

Sources: "Temperature Screening Logs"; home's policy; and interview with ADES. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 4.

The licensee failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an incident involving a resident with a sustained injury as required in mandatory reporting.

Rationale and Summary: A RN Charge Nurse and a RPN did not notify the Director of an incident involving a resident with a sustained injury.

A Critical Incident (CI) report was submitted to the Director days after the incident occurred.

There was no risk to the resident when the home failed to immediately report the incident to the Director.

Sources: CI report; and an interview with ADOC. [613]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.

The licensee has failed to make a report in writing to the Director setting out the analysis and follow-up action, including long-term actions planned to correct the situation and prevent recurrence.

Rationale and Summary: A CI report was submitted to the Director on a specific date. The Director requested an amendment by a deadline to identify interventions with updates to the plan of care to correct the situation and prevent recurrence. The home did not amend the CI report with the requested information by the deadline as requested.

The ADOC was unaware the amendment to the CI report was late.

Sources: CI report; and an interview with ADOC. [613]