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: August 23, 2024

Inspection Number: 2024-1119-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Van Daele, Sault Ste. Marie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1-2 and 6-8, 2024.

The following intake(s) were inspected:
· Intake related to air temperatures and cooling requirements
·Intake related to provision of care
· Intake related to an outbreak

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 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 has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning devices and techniques when assisting a resident.

Rationale and Summary: A resident had instructions on their care plan related to transferring and positioning during care that were not followed, resulting in a fall and injury to a resident.

The Assistant Director of Care (ADOC) confirmed that a PSW had provided unsafe care to a resident.

There was moderate risk and impact to the resident when a PSW unsafely transferred and positioned a resident during care.

Sources: Critical Incident (CI) report; Investigation file; A resident's health care records; Safe Lifting with Care Program policy; Interviews with ADOC and other staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 1.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The licensee has failed to make a report in writing to the Director setting out a description of the incident, including the events leading up to the incident.

Rationale and Summary: A CI report was submitted to the Director on a specific date. The Director requested an amendment by a deadline; however, the home did not amend the CI report with the requested information by the deadline as requested.

The Administrator (ADM) confirmed the amendment to the CI report was late.

There was no risk to a resident when the home to failed to amend the CI report by the deadline.

Sources: CI report; and an interview with ADM.

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