Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2021	2021_638542_0023	009036-21, 010140-21, 011891-21, 013744-21	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue Sault Ste. Marie ON P6B 6G3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER LAURICELLA (542), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 27 - 29 and October 1, 4, 5, 6, 7, 2021.

This Inspection was conducted concurrently with Follow Up Inspection #2021_638542_0022 and a Complaint Inspection #2021_638542_0021.

During this Inspection the following intakes were completed:

Two intakes, related to resident falls with injuries,

One intake, related to alleged staff to resident abuse, and

One intake, related to resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Cares (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff and residents.

The Inspectors conducted daily observations of the provision of care being provided to the residents, reviewed resident health care records, Infection Prevention and Control practices and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of a resident, or unlawful conduct by a staff that resulted in risk of harm to a resident immediately reported the suspicion to the Director. Pursuant to s.152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

An alleged incident of abuse occurred when a Personal Support Worker (PSW) was observed by another PSW to place a cloth over a resident's mouth to prevent them from exhibiting a responsive behaviour. The alleged incident occurred on a specific day in June, 2021, however it was not reported by the PSW that witnessed the incident until two days later.

The home's investigation file included documentation that verified that the alleged physical abuse was not reported by the PSW that witnessed the incident to the home's management team, until 2 days after the incident.

The home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy (RC-02-01-02) last updated June 2021, identified that any employee who witnessed a resident incident of abuse would report it immediately to the most senior Supervisor on shift at the time.

Sources: CI Report #3043-000022-21; the policy titled "Prevention of Abuse and Neglect of a Resident; home's investigation documents; Administrator and ADOC's interview. [s. 24. (1)]

Issued on this 2nd day of November, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.