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
Feb 9, 2022	2022_822613_0002	016502-21, 017515-21, 018712-21, 019483-21, 000153-22	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

LISA MOORE (613)

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): January 24-28 and Febraury 1-2, 2022.

The following intakes were inspected during this Inspection:

Three Critical Incident (CI) reports regarding a resident fall resulting with an injury and transfer to the hospital;

One CI report regarding allegations of staff to resident neglect; and

One CI report regarding resident to resident abuse.

A concurrent Complaint Inspection #2022_822613_0001 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Assistant Directors of Care (ADOCs), Physiotherapist, Behavioural Supports Ontario Registered Nurse (BSO RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, infection prevention and control (IPAC practices), staff to resident interactions, reviewed health care records, and various licensee's policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by another resident.

Physical abuse is defined within Ontario Regulation 79/10 as, the use of physical force by a resident that causes physical injury to another resident.

A resident had an altercation with another resident that caused a resident to fall sustaining injuries.

The resident had a history of responsive behaviours which various staff members indicated they were aware.

The strategies for managing a resident's responsive behaviours failed to prevent abuse towards another resident and resulted in actual harm.

Sources: CIS report; the home' investigation notes; the licensee's Abuse of Residents, Preventing, Reporting & Eliminating policy; resident's plan of care and interviews with the ADOC and other staff. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by another resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity was respected and promoted.

A PSW was observed using their cell phone in a resident's room. The cell phone was on speaker and the conversation could be heard down the hallway. The PSW had their back to the resident and did not acknowledge or attempt to communicate with the resident when the resident was repeating the same statement out loud.

A RPN verified that staff were not permitted to use their cell phones in resident's rooms.

The failure of a PSW not respecting and promoting a resident rights put the resident at risk of not having their needs met in a prompt manner.

Sources: Observations; Interviews with the PSW and RPN. [s. 3. (1) 1.]

Issued on this 11th day of February, 2022

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

Original report signed by the inspector.