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_0001	019285-21	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): January 24-28 and February 1-2, 2022.

The following complaint was inspected during this inspection:

One Complaint regarding concerns with infection prevention and control practices.

A concurrent Critical Incident Inspection #2022_822613_0002 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), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff 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:
Infection Prevention and Control

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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they developed an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents.

Two registered staff administered medications to the residents when a resident home area was on an outbreak. During an outbreak on a unit, registered staff #110 prepared the medication(s) and provided the medication(s) to another registered staff #112, who administered the prepared medication(s) to the residents. Registered staff #112 did not perform the double check verification prior to administering the medications to the residents. Registered staff #112 stated they were trusting that registered staff #110 had poured the medications correctly.

The failure of registered staff #112 not ensuring the medications had been safely prepared for administration, including the 8 rights, put the residents at risk of receiving the incorrect medication(s) and dosages.

Sources: Complainant; the licensee's Medication Management and High-Alert Medications policies; and interviews with ADOC and registered nurses. [s. 114. (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.