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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date August 8, 2022
Inspection Number 2022_1471_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare Maple View

Long-Term Care Home and City
Extendicare Maple View, Sault Ste Marie

Inspector who Amended
Jennifer Lauricella #542

Inspector who Amended Digital Signature
Jennifer Lauricella
Digitally signed by Jennifer Lauricella
Date: 2022.08.19 15:33:43 -04'00'

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the removal of the WN #001 related to LTCHA, 2007, s. 44 (9). The Complaint and Critical Incident inspection #2022_1471_0001 was completed May 16-20 and May 24-26, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 16 – 20 and May 24 – 26,

2022 The following intake(s) were inspected:

- Three intakes, related to falls with injuries;
- One intake, related to alleged staff to resident abuse;
- Two intakes, related to an injury of a resident;
- One intake, related to a medication error;
- One intake, related to a resident elopement and
- One Complaint intake, related to Infection Prevention Control practices and menu choices.

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

LTCHA, 2007, s. 44 (9)

A complaint was received by the Director identifying that the licensee denied an applicant admission to the home.

The Interim Director of Care (Interim DOC) provided the application forms that the home had received and indicated that the applicant had been denied admission. The Interim DOC was unable to locate a written notice created by the former DOC.

The Interim DOC sent a late written notice to the applicant, indicating the reason for the admission refusal.

Date Remedy Implemented: May 17, 2022 (613)

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-Compliance with O. Reg. 79/10, s. 131 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for as specified by the prescriber.

Rationale and Summary: A resident was admitted to the home; however, their scheduled medications, which included essential medications, were not available. As a result of medications not being available, the resident did not receive their bedtime dose of medications on that specific day and their morning dose of medications the

next day. The resident had two medical emergencies and was transferred to the hospital as a result of not receiving their prescribed medications.

The Administrator and ADOC stated that the resident did not receive their scheduled medications as ordered and the registered staff did not notify the Physician/NP that the medications were not available, as stated in the licensee's policy.

The failure of registered staff to ensure that drugs were administered to the resident in accordance with the directions for as specified by the prescriber and not ensuring that the medications were available resulted in actual harm and risk to the resident, requiring transfer to the hospital.

Sources: CI Report; Resident's February MAR; Resident's progress notes; Medication Management Policy (RC-03-01-01), last updated June 2021 and various Pharmacy policies; the Home's Investigation File and interviews with the Administrator, ADOC, and other relevant staff members.

COMPLIANCE ORDER CO #001: TRANSFERRING AND POSITIONING TECHNIQUES

NC#003 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 79/10 s. 36 and O.Reg. 246/22, s. 40

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10 s. 36 and O.Reg. 246/22, s. 40

The licensee shall ensure that:

1. Two PSWs receive an individual review of the incident and a review of the applicable policies and procedures in order to prevent reoccurrence.

2. A record of this review, including who participated and what was reviewed, shall be kept.

3. Provide all staff, with communication, to reinforce the importance and necessity of following applicable protocols, while pushing residents in their wheelchairs, by August 22, 2022.

Grounds

1) Non-Compliance with: O. Reg. 79/10, s. 36

The licensee has failed to ensure that proper positioning techniques were used when assisting a resident in their wheelchair.

Rationale and Summary

A resident sustained an injury while a PSW was assisting them in a mobility device.

The progress notes identified that a nurse had assessed the resident's injured area and did not observe any abnormalities.

A physician indicated that the resident required further testing, which revealed an injury to the resident.

The home's investigation file revealed that the PSW received a coaching letter for a policy/procedure violation.

The resident was improperly transferred in their mobility device that resulted in a significant injury to the resident.

Sources: CIS report, licensee's investigation documents, the resident's progress notes and interviews with the PT and ADOC.

2) Non-Compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A resident sustained an injury while a PSW was assisting them in a mobility device.

The resident was assessed, and no injuries were noted. The resident's health status deteriorated the next day, and they were transferred to the hospital, where they were assessed to have injuries.

The home's investigation file revealed that the PSW received a coaching letter for a policy/procedure violation.

The Physiotherapist (PT) confirmed that the PSW improperly positioned the resident, in their mobility device.

The Assistant Director of Care (ADOC) further commented that the PSW did not follow best practice when positioning and transferring the resident in their mobility device.

The resident was improperly transferred in their mobility device that resulted in a significant injury to the resident.

Sources: CIS# 3043-000041-22; the licensee's investigation notes, the resident's progress notes and interviews with the PT and the ADOC.

This order must be complied with by August 22, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order AMP #001

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s. 40

Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification (NC) #003

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **1100.00** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Compliance Order #001 of Inspection # 2020_740621_0005, O. Reg. 79/10 s. 36

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

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NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the *Fixing Long-Term Care Act, 2021*, the licensee is subject to a re-inspection fee of **$500.00** to be paid within 30 days from the date of the invoice.

*Licensees must **not** pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.*

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.