Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: May 9, 2023	
Inspection Number: 2023-1471-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Maple View of Sault Ste. Marie, Sault Ste. Marie	
Lead Inspector Sylvie Byrnes (627)	**Inspector Digital Signature** Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2023.05.11 08:46:41 -04'00'
Additional Inspector(s) Chad Camps (609)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-28, 2023.

The following intakes were completed:

- Fifteen intakes related to falls;
- Twenty-two intakes related to resident to resident abuse;
- One intake related to safe transfers;
- One intake related to medication administration;
- One intake related to a complaint regarding care concerns; and,
- One intake related to a complaint regarding discharge of a resident.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

Rationale and Summary

A resident was transferred with a mechanical lift solely operated by one staff member. The Assistant Director of Care (ADOC) indicated that two trained staff were required to operate a mechanical lift when transferring a resident; One person to operate the lift and another person to ensure the resident's safety.

The home's failure to ensure that staff used safe transferring techniques when assisting a resident caused minimal harm to the resident.

Sources: Interviews with a resident and ADOC; record review of a resident's care plan, home's policy titled, "Mechanical Lifts" and a surveillance video.

[627]

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee has failed to ensure that a RPN complied with the home's medication management system when a resident experienced an incident of severe hypoglycemia.

Rationale and Summary

Pursuant to Ontario Regulation (O. Reg.) 246/22 s. 11 (1) b, the licensee is required to develop and comply with an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Specifically, a RPN did not comply with the home's policy titled "Diabetes Management – Hypoglycemia" which required a resident's blood glucose (BG) be retested and retreated every 15 minutes until the BG was greater than 4.0 millimoles per liter (mmol/L).

A resident's BG read below 4.0 mmol/L. on two occasions of BG testing, taken 30 minutes apart. The resident's BG was not re-tested for over three hours at which time the resident was transferred to the hospital for hypoglycemia.

The DOC and an RN verified that the RPN should have retested and retreated the resident's BG, which the DOC indicated should have been every 15 minutes until it was greater than 4.0 mmol/L.

The home's failure to ensure that the RPN complied with the home's medication management system and retested/retreated the resident's BG every 15 minutes until greater than or equal to 4.0 mmol/L presented moderate risk to the resident.

Sources: The home's internal investigation notes; The home's policy titled "Diabetes Management – Hypoglycemia; CI report ; a resident's health care records; Interviews with an RN and the DOC. [609]