Ontario

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

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

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

Public Report

Report Issue Date: July 23, 2025

Inspection Number: 2025-1471-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Maple View of Sault Ste. Marie, Sault Ste. Marie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 7 - 11, 2025.
The inspection occurred offsite on the following dates: July 14, 2025.

The following intakes were inspected:

- An intake related to a medication incident;
- An intake related to improper/incompetent care of a resident by staff;
- An intake related to alleged abuse of a resident by staff;
- An intake related to alleged neglect of a resident by staff;
- An intake related to a resident fall with injury;
- An intake related to a complaint re: resident care; and
- An intake related to a complaint re: palliative care of a resident.

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

Skin and Wound Prevention and Management
Continence Care

Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Palliative Care
Pain Management
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure doors leading to non-residential areas were kept locked.

A door to a non-residential area was observed to be unlocked during the inspection.

Sources: Observations conducted on July 8, 2025; and an interview with a staff member.

Date Remedy Implemented: July 11, 2025

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with home's Falls Prevention and Management Program related to a resident's fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

A resident sustained an injury from an unwitnessed fall and a full comprehensive post fall assessment including the Clinical Monitoring Record was not conducted as required in the falls prevention and management program.

Sources: The home's Falls Prevention and Management Program: Post Fall Assessment policy; A resident's clinical records; and interview with a staff member.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that the proper use of PPE, was followed.

Staff were observed providing care without utilizing personal protective equipment for a resident with additional precautions signage posted on their door.

Sources: Observations conducted; and an interview with the IPAC lead.

WRITTEN NOTIFICATION: Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to respond to a written complaint that alleged resident harm.

A written complaint was submitted to the home that alleged improper care of a resident and there was no written response to the complaint addressing the allegation.

Sources: Letter of complaint and response to the complainant; Associated CI report; Licensee policy: Complaints and Customer Service, last reviewed June 2025; and an interview with a staff member.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection

(2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1.Develop and implement re-training for registered staff related to the appropriate assessment tools and documentation required for residents with wounds, as per the licensee skin and wound care program.

2.Conduct weekly audits, over a period of four weeks, of a resident, to ensure the correct skin and wound assessment tools and documentation were completed.

3.Maintain documentation of the actions completed for Part 1 and 2 of this order.

Grounds

The licensee failed to ensure a resident received a wound assessment using an clinically appropriate assessment instrument specific to wounds.

A resident had an area of impaired skin integrity as indicated in their health care records.

A clinically appropriate assessment tool was not used that would capture the specific details of the wound that would indicate deterioration.

Sources: Review of a resident's health care records including skin assessments; Progress notes; Licensee policy: Skin and Wound Program: Wound Care Management, last reviewed June 2025; Complaint letter submitted to the home;

and interviews with staff members.

This order must be complied with by September 29, 2025

COMPLIANCE ORDER CO #002 Administration of drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1.Prepare the scenario involving a resident as a case study and include factors to mitigate reoccurrence. Present this case study to all registered staff who work regularly in the home, to enhance their awareness and learning regarding safe medication administration.

2. Keep a documented record of the case study presentation; the dates and names of registered staff that participated.

Grounds

The licensee failed to ensure a resident was administered drugs as prescribed.

A resident was administered drugs in error that had not been prescribed for them

which resulted in a change of condition.

Sources: Review of CI report; Health care records for a resident; Homes' investigation file; and an interview with a staff member.

This order must be complied with by September 29, 2025

COMPLIANCE ORDER CO #003 Pain management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Develop and implement in-person training for all registered staff who are regularly employed in the home, to review requirements for pain assessments as per the licensee's Pain Identification and Management Program policy. Training shall include, but not be limited to, differentiation between instances where a full pain assessment is required by the licensee's policy and instances when numeric and/or the PAINAD pain assessment is required prior to and after administration of as needed (PRN) narcotic analgesics.

2. Ensure that a written record of the training, including who provided the training, the date and time the education was provided and the names of staff participating

in the training is maintained.

3. Conduct audits on three resident records for a period of 4 weeks to ensure that full pain assessments and assessments required prior to and after administration of PRN narcotic analgesics are completed as required. Implement corrective action to address any deficiencies identified through the auditing process and maintain documentation of the corrective action that was implemented.

Grounds

The licensee has failed to ensure when a residents pain was not relieved by initial interventions, the registered staff completed a comprehensive pain assessment.

a) Specifically, a resident exhibited signs of increased pain, as evidenced by a marked escalation in the use of breakthrough pain medication. During this period, no pain assessment was conducted.

Sources: A resident's health care records including progress notes and medication administration; Home's Policy: "Pain Identification and Management" last reviewed June 2025; and interviews with staff members.

b) Specifically, a staff member reported to a registered staff member that during care, a resident exhibited signs of pain upon being moved. The resident continued to complain of pain but was not provided with a comprehensive pain assessment nor was the physician contacted related to the new onset of pain.

Sources: A resident's health care records including progress notes; Home's Policy: "Pain Identification and Management" last reviewed June 2025; and interviews with staff members.

c). Specifically, a resident displayed signs of increased discomfort and resulted in changes to their pain medications and a comprehensive pain assessment was not conducted during this time.

Sources: A resident's health care records, Home's Policy: "Pain Identification and Management" last reviewed June 2025; and interviews with a staff member.

This order must be complied with by September 29, 2025

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.