Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 24, 2019	2019_638542_0026	018793-19, 018821-19	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 4J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER LAURICELLA (542)

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): September 30, 2019 and October 1, 2, 4, 2019.

One complaint intake was submitted to the Director, related to the unexpected death of a resident and care related concerns and,

One Critical Incident intake that was submitted to the Director regarding the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), the Medical Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services

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

2 WN(s)
2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A Critical Incident (CI) report was submitted to the Director, for the unexpected death of resident #001.

A complaint was submitted to the Director, by a family member of resident #001 indicating that they had care related concerns and that they were not notified of resident #001's deteriorating health status.

Inspector #542 reviewed the home's policy titled, "Notification of Family/Substitute Decision-Maker", RC-11-01-06. It was documented in the policy that they were to notify the Substitute Decision Maker (SDM) or the Power of Attorney (POA) when there was a significant change in medical health or condition that could negatively impact the resident's comfort or well-being.

Inspector #542 interviewed PSW #104 who worked on the day that resident #001 passed away. PSW #104 indicated that resident #001 did not attend breakfast or lunch as they were feeling unwell.

Inspector #542 interviewed RPN #103 who indicated that resident #001 had experienced a change in health status. Inspector #542 asked if they notified the SDM/POA of resident #001's change in health status. RPN #103 indicated that they did not.

Inspector #542 interviewed the Director of Care, who indicated that RPN #103 was to receive progressive discipline for not notifying the family of the significant change in resident #001's health status. [s. 6. (5)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, the symptoms were recorded and that immediate action was taken as required.

A Complaint and a CI report were submitted to the Director, outlining that resident #001 had passed away unexpectedly.

Inspector #542 reviewed the health care records for resident #001. It was documented in the progress notes located on PointClickCare (PCC) that resident #001 had specific symptoms. A review of the Electronic Medication Administration Record (EMAR) was completed. There was no documentation on the EMAR to indicate that resident #001 was provided with medications to alleviate their symptoms. A review of the “Weights and Vitals Summary” located on PCC was completed. There was no documentation of resident #001’s vital signs being assessed.

Inspector #542 interviewed the Infection Prevention and Control lead #102 who indicated that the registered staff were to complete a full set of vital signs on residents that were on the line listing for tracking of infections. They further indicated that this included an assessment of the resident’s blood pressure, pulse, oxygen saturations, respirations and temperature; all of which should have been completed on resident #001.

Inspector #542 interviewed RPN #103 who indicated that they did not complete a full assessment on resident #001, nor did they provide the resident with any medications for the symptoms they were experiencing.

A review of the video surveillance, revealed that neither the day shift or evening shift registered staff completed a full set of vital sign assessments on resident #001.

Inspector #542 interviewed the DOC who confirmed that neither of the day shift or evening shift Registered Practical Nurses completed a thorough assessment of resident #001’s vital signs nor did they provide them with any medications to alleviate their symptoms. [s. 229. (5) (b)]

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 on every shift, (b) the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

Issued on this 30th day of October, 2019

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

Original report signed by the inspector.