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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 06, 2020	2020_740621_0005 (A1)	022006-19, 023545-19, 023726-19, 024454-19, 000212-20, 001393-20	Critical Incident System

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

Amended by TRACY MUCHMAKER (690) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to compliance order #001 is granted to allow the home to achieve sustainable compliance. CDD date changed from April 10, 2020 to May 15, 2020.

Issued on this 6 th day of March, 2020 (A1)

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

Original report signed by the inspector.

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

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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

Amended by TRACY MUCHMAKER (690) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 3 - 7, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- Four intakes related to resident falls with injury; and

- Two intakes related to unexpected resident deaths.

A Follow Up inspection (#2020_740621_0003) and Complaint inspection (#2020_740621_0004) were conducted concurrently with this inspection.

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

The Inspector also reviewed relevant resident health care records, internal incident and investigation reports, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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

1 WN(s)
0 VPC(s)
1 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #008.

Inspector #613 reviewed a Critical Incident System (CIS) report that was submitted to the Director on a day in December 2019, which identified that resident #008 had a fall and sustained an injury.

The Inspector reviewed the home's internal investigation file which revealed PSW #138 failed to follow the licensee's policy titled, "Mechanical Lift Procedure" and did not use safe transferring techniques when assisting resident #008.

A review of the licensee's policy titled, "Mechanical Lifts Procedure: (LP-01-01-03)", last updated December 2019, identified that two people were required at all times, when transferring a resident with a mechanical lift. Further, the policy identified that two people were required when inserting/applying the sling, centering the resident on the sling, positioning the resident's arms inside the sling, and when removing the sling from underneath the resident.

A review of a specific assessment completed at the time of the fall, identified that resident #008 required a specified level of assistance from two staff members and required the use of a specific piece of equipment for transfers. Additionally, a review of the resident's care plan also identified resident #008 required a specified level of assistance of two staff members when using a specific piece of equipment for transfers, and that the resident utilized a specific safety device when they were positioned in their mobility aide.

During an interview with PSW #115 and RPN #116, they both stated that two staff members were required to be present during the entire transfer process.

During an interview PSW #138, they stated that they had not followed the licensee's policy when they completed a certain transfer activity with resident #008 on their, and that they should have had another PSW present to assist.

During an interview with the Director of Care (DOC), they verified that PSW #138 did not use safe transferring techniques with resident #008 during the identified incident, and they did not follow the licensee's policy for safe transfers. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #007.

Inspector #613 reviewed a CIS report that was submitted to the Director on a day in December 2019, which identified that resident #007 had a fall, resulting in injury.

The Inspector reviewed the home's internal investigation file which revealed that PSW #136 and RPN #137 had transferred resident #007 manually, which placed the resident and staff at risk of injury and was a violation of the licensee's policy.

A review of the licensee's policy titled, "Safe Lifting with Care Program (LP-01-01-01)", last updated in December 2019, identified that Extendicare was a zero lift facility and that the zero lift program was integrated with the safe lifting with care program. Further, the policy identified that the zero lift system was designed to eliminate all manual resident lifting and handling through the use of appropriate devices, for the purposes of improving resident quality of life and reducing injuries to staff

During an interview with PSW #134 and RPN #135, they both stated that the home had a zero lift policy and that they were never allowed to lift a resident manually off of the floor, and that specific equipment must be used with two staff members.

During an interview with ADOC #103, they verified that PSW #136 and RPN #137 did not use safe transferring techniques when assisting resident #007, which resulted in a fall with injury, that they had not followed the home's policy for zero lifting, and that they should have used specific equipment. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 6 th day of March, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TRACY MUCHMAKER (690) - (A1)
Inspection No. / No de l'inspection :	2020_740621_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022006-19, 023545-19, 023726-19, 024454-19, 000212-20, 001393-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 06, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-6G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Freeman

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

(a) Ensure all PSW and RPN staff are compliant with the home's policies including: "Mechanical Lifts Procedure: (LP-01-01-03)" and "Safe Lifting with Care Program (LP-01-01-01)", as part of the home's adherence to Extendicare's Zero Lift policy and program requirements; and

b) Complete randomized weekly audits of residents who require specific equipment for transfers, to ensure PSW and RPN staff, on all shifts, are compliant with the home's policies. The home is to keep a record of who completed each audit, including the date/time of the audit, the name of the resident, details of the resident's transfer care plan in place, any variances found, and corrective action taken.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #008.

Inspector #613 reviewed a Critical Incident System (CIS) report that was submitted to the Director on a day in December 2019, which identified that resident #008 had a fall and sustained an injury.

The Inspector reviewed the home's internal investigation file which revealed PSW #138 failed to follow the licensee's policy titled, "Mechanical Lift Procedure" and did not use safe transferring techniques when assisting resident #008.

A review of the licensee's policy titled, "Mechanical Lifts Procedure: (LP-01-01-03)", last updated December 2019, identified that two people were required at all times, when transferring a resident with a mechanical lift. Further, the policy identified that two people were required when inserting/applying the sling, centering the resident on the sling, positioning the resident's arms inside the sling, and when removing the sling from underneath the resident.

A review of a specific assessment completed at the time of the fall, identified that resident #008 required a specified level of assistance from two staff members and required specific equipment for transfers. Additionally, a review of the resident's care plan also identified resident #008 required a specified level of assistance of two staff members when using specific equipment for transfers, and that the resident utilized a specific safety device when they were positioned in their mobility aide.

During an interview with PSW #115 and RPN #116, they both stated that two staff members were required to be present during the entire transfer process.

During an interview PSW #138, they stated that they had not followed the licensee's policy when they completed a certain transfer activity with resident #008 on their, and that they should have had another PSW present to assist.

During an interview with the Director of Care (DOC), they verified that PSW #138 did not use safe transferring techniques with resident #008 during the identified incident, and they did not follow the licensee's policy for safe transfers. [s. 36] (613)

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #007.

Inspector #613 reviewed a CIS report that was submitted to the Director on a day in December 2019, which identified that resident #007 had a fall, resulting in injury.

The Inspector reviewed the home's internal investigation file which revealed that PSW #136 and RPN #137 had transferred resident #007 manually, which placed the resident and staff at risk of injury and was a violation of the licensee's policy.

A review of the licensee's policy titled, "Safe Lifting with Care Program (LP-01-01-01)", last updated in December 2019, identified that Extendicare was a zero lift facility and that the zero lift program was integrated with the safe lifting with care program. Further, the policy identified that the zero lift system was designed to eliminate all manual resident lifting and handling through the use of appropriate devices, for the purposes of improving resident quality of life and reducing injuries to staff

During an interview with PSW #134 and RPN #135, they both stated that the home had a zero lift policy and that they were never allowed to lift a resident manually off of the floor, and that specific equipment for transfers must be used with two staff members.

During an interview with ADOC #103, they verified that PSW #136 and RPN #137 did not use safe transferring techniques when assisting resident #007, which resulted in a fall with injury, that they had not followed the home's policy for zero lifting, and that they should have used specific equipment. [s. 36.]

The severity of the issue was determined to be level 3, as there was actual harm to the residents inspected. The scope of the issue was a level 2, as there was a pattern of occurrence present. The home had a level 3 compliance history, as it had previous non-compliance with the same subsection of Ontario Regulation 79/10 within the previous 36 months as follows:
- a VPC was issued on December 22, 2017, in Complaint inspection report #2017_616542_0018 and Critical Incident System inspection report #2017_616542_0019. (613)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 15, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6 th day of March, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by TRACY MUCHMAKER (690) - (A1)

Ontario

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Service Area Office / Bureau régional de services : Sudbury Service Area Office