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


## Public Copy/Copie 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 |
|---|---|---|---|
| Jun 11, 2020 | 2020_638542_0009 | 003636-20, 004140-20, 004413-20 | 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 6G3

### 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): May 28, 2020 and June 1-4, 2020.**

**The following intakes were inspected during this Complaint Inspection;**

**Two intakes, related to the fall prevention interventions and personal care of a resident and;**

**One intake, related to alleged staff to resident abuse.**

**A Follow Up Inspection #2020_638542_0010 was conducted concurrently with this inspection.**

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

**The Inspector conducted observations of the provision of care provided to residents, reviewed relevant resident health care records, internal documents and policies and procedures relevant to the intakes.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Falls Prevention**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A complaint was submitted to the Director outlining concerns regarding resident #001's fall prevention interventions not being in place prior to their fall. The complainant indicated that resident #001 fell from their wheel chair as the home failed to ensure that fall prevention interventions were in place.

Inspector #542 reviewed resident #001's health care record. It was documented in the progress notes that resident #001 had a fall in, December, 2019, and sustained an injury. In January, 2020, resident #001 returned to the home and the Physiotherapist (PT) completed an assessment. The PT assessment indicated that it had been determined with the Substitute Decision Maker (SDM) that a specific fall prevention intervention would be provided to the resident. Furthermore, the documentation indicated that the SDM also wanted the resident to have an additional fall prevention intervention in place.

Inspector #542 reviewed resident #001's care plan that was in place after the PT assessment. The care plan did not indicate the new fall prevention intervention that was previously discussed with the SDM.

A further review of the progress notes was conducted. It was documented in March, 2020, that resident #001 fell from their wheel chair. Two days after the fall, the fall prevention intervention was added to the resident's care plan. Therefore, from January, 2020 to March, 2020, the fall prevention intervention was not added to the care plan.

Inspector #542 interviewed PSW #100, who indicated that resident #001 was to have the specific fall prevention intervention in place while the resident was in their wheel chair.

Inspector #542 interviewed the Director of Care (DOC) who indicated that the fall prevention intervention was not in place when the resident had fallen in March, 2020. The DOC acknowledged that the care plan was not updated with the intervention. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed, no later than one business day after the occurrence of the incident, followed by a report required under subsection (4): 4. Subject to subjection (3.1), an incident that caused injury to a resident, for which the resident was taken to hospital, and that resulted in a significant change in the resident's health condition.

A complaint was received by the Director, which identified that resident #001 had sustained a fall with a fracture, and that a critical incident report was not submitted to the Director, as required. The complainant indicated that they had concerns regarding the resident's fall.

Inspector #542 was unable to locate a Critical Incident (CI) Report that had been submitted to the Director.

Inspector #542 interviewed the Administrator and the Director of Care (DOC) who both confirmed that a CI report was not submitted to the Director as per requirements. [s. 107. (3)]

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**Issued on this 12th day of June, 2020**

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

**Original report signed by the inspector.**