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

Original Public Report

Report Issue Date: March 27, 2023

Inspection Number: 2023-1471-0003

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	**Inspector Digital Signature**
Jennifer Lauricella (542)	Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2023.05.01 12:54:42 -04'00'

Additional Inspector(s)
Lisa Moore (613)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
Jan 31/23, Feb 2-3 and Feb 6-8/23

The following intake(s) were completed:

- Two intakes related to controlled substances missing/unaccounted;
- Two intakes related to resident care concerns;
- One intake related to neglect of a resident;
- Two intakes related to resident to resident emotional abuse;
- Three intakes related to resident to resident sexual abuse;
- Three intakes related to resident care concerns and improper/incompetent care of a resident and
- One intake related to improper/incompetent care of a resident.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

The licensee has failed to ensure that every resident had the right to freedom from abuse.

Emotional abuse is defined within Ontario Regulation 246/22 as, any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

On two occasions, a resident spoke to a co-resident in an inappropriate manner which emotionally impacted them.

A review one of the resident's progress notes identified that they had a history of verbally responsive behaviours towards other residents, and specifically towards the identified co-resident.

During interviews with various staff members, they all indicated they were aware of the resident's history of responsive behaviours and the verbal/emotional abuse towards the co-resident and the impact it had on them.

The interventions in place for managing the resident's responsive behaviours were ineffective in

preventing emotional abuse towards the co-resident and resulted in moderate harm for them.

Sources: CIS reports; the home's investigation notes; the licensee's Zero Tolerance of Resident Abuse and Neglect Program, dated January 2022; both residents' progress notes and care plans and interviews with DOC, ADOC #102 and other staff. [613]

WRITTEN NOTIFICATION: Duty to Protect

NC #1 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse and not neglected by four PSWs.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A complaint was submitted to the Director outlining concerns regarding a resident being left unattended without being provided with assistance for one of the their activities of daily living (ADLS) for an extended period of time. Additionally, a Critical Incident (CI) report was submitted to the Director regarding the same concern.

A review of the home's investigation file was completed. It was documented that the resident was not provided with the assistance that they required for an extended period of time, which caused them to experience discomfort.

Interviews with the Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed that the staff were re-educated on providing proper and timely assistance with ADLs to the residents.

They further indicated that the staff put the resident at risk for pain and skin breakdown by not providing assistance with ADLs in a timely fashion.

There was a moderate level of risk of harm to the resident by not being providing care in a timely and correct manner.

Sources: CI report; home's investigation files; the residents' health care records and interviews with the DOC and the ADOC. [542]

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