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: June 7, 2024
Inspection Number: 2024-1471-0003
Inspection Type: Proactive Compliance Inspection
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**
Lisa Moore (613)	Lisa K Moore Digitally signed by Lisa K Moore Date: 2024.06.07 16:30:35 -04'00'

Additional Inspector(s)
Ali Nasser (523)
Cheryl McFadden (745)
Jennifer Lauricella (542)
Tracie Dodkin (000875) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-16, 2024.

The following intake(s) were inspected:

- Intake related to a Proactive Compliance Inspection (PCI) Inspection

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary: A resident was provided an intervention that was not ordered by the Registered Dietitian (RD).

A Registered Practical Nurse (RPN) and the RD confirmed that the resident had received an intervention that was not part of the resident's care plan.

There was a potential risk to the resident's health and safety when they were provided with an intervention that was not part of their care plan.

Sources: Observations; care plan and progress notes; and interviews with a RPN and the RD. [542]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

Rationale and Summary: During the initial tour of the home, some residents were observed in their rooms and did not have access to their resident-staff communication and response system.

A PSW and the Director of Care (DOC) confirmed that residents were to always have access to their resident-staff communication and response system when in their rooms.

Failure to ensure that the resident's had access to their resident-staff communication and response system, placed them at a risk of not being able to alert the staff regarding their need for assistance.

Sources: Observations; and interviews with a PSW and the DOC. [542]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

Rationale and Summary: On two occasions, a resident was observed unsupervised while consuming a meal in their room. The resident's care plan identified them as a nutritional risk.

The RD and DOC indicated that all residents were to be monitored by staff during their meals, whether they were in their room or the dining room.

The home's failure to ensure that a resident was monitored during their meal placed them at a risk for choking.

Sources: Observations; care plan and progress notes; and interviews with the RD and DOC. [542]

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