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: September 27, 2024
Inspection Number: 2024-1471-0005
Inspection Type: Complaint Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Maple View of Sault Ste. Marie, Sault Ste. Marie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 9-12, 2024.

The following intake(s) were inspected:
• Intake related to zero tolerance of abuse and neglect policy compliance;
• Intake related to allegations of neglect;
• Intake related to a medication incident resulting in harm;
• Intake related to a fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1471-0004 related to FLTCA, 2021, s.

25 (1).

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: Falls Prevention & Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary: A resident had a fall and a RN assessed the

resident and determined no injuries were identified. The RN had not used a clinically appropriate assessment instrument that was specifically designed for falls.

The Director of Care (DOC) confirmed that a RN had not completed the post falls management procedure at the time of the resident's fall as per the home's policy.

The risk and impact was low to the resident when a RN failed to complete the post falls assessment procedures.

Sources: CIS report; Resident's health care record including progress notes & assessments; investigation file; Falls Prevention & Management Program policy; and an interview with the DOC.

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