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

Public Report

Report Issue Date: December 20, 2024

Inspection Number: 2024-1471-0006

Inspection Type:
Complaint
Critical Incident

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 date(s): December 2, 3, 4, 5, 6, 9, 2024

The following intake(s) were inspected:

- One intake related to, improper/incompetent care of a resident;
- One intake related to, a complaint concerning falls of a resident and
- One intake related to, a complaint regarding a fall and improper care of a resident

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that the staff and others involved in the different aspect of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Physiotherapist (PT) for the home had assessed the resident post fall and had recommended that the staff use a different intervention when providing care. In an interview with the RAI Coordinator, they confirmed that the recommendation had not been brought forward to the rest of the staff.

Sources: The residents health care records, interviews with the PT and the RAI coordinator.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

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,

(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Interviews with numerous staff members concluded that a resident had numerous falls without a reassessment when the fall prevention interventions were no longer effective.

Sources: The residents health care records; falls committee meeting minutes and interviews with the Physiotherapist (PT), the Falls Lead and an Assistant Director of Care (Falls Manager).

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information up which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident.

One of the home's previous ADOC's and the home's DOC were made aware of an incident, however it was not reported to the Director.

Sources: The residents health care records and interview with a PSW, a RPN, the PT and the DOC.

COMPLIANCE ORDER CO #001 Falls prevention and management

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall create a plan that ensures that the Falls Program policy is complied with.

The plan shall include but is not limited to:

1) Ensure that a comprehensive interdisciplinary review is completed on all residents who have been assessed as a high risk for falls, specifically reviewing if their current fall prevention interventions are appropriate for them. A copy of the review shall be documented, with the date of the review, outcome and who completed the review;

2) Conduct a documented review of the fall prevention equipment that is currently in the home to ensure that the supply is sufficient to meet the assessed needs of residents. Develop a plan to ensure that any deficiencies identified in the review are corrected.

Grounds
The licensee has failed to ensure that the home's falls prevention and management program which provided for strategies to reduce or mitigate falls was followed.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and that it was complied with.

A resident sustained numerous falls, with the last fall resulting in a fracture. The falls committee did not meet to review resident falls, look for trends and develop strategies to prevent falls. During observations and interviews, it was noted that some of the home's falls equipment had been on back order for approximately six months. No other vendors/suppliers were contacted to obtain the equipment.

Furthermore, during interviews it was mentioned that home had not been reviewing the program regularly to ensure that residents who no longer met the criteria were removed from the program nor was the home completing post-fall team huddles on a consistent basis.

There was actual risk to the resident due to the home not following their Falls Program Policy.

Sources: Review of the residents health care record; observations; the home's "Falls Management Program" policy #RC-15-01-01 revised March 2023, and interviews with the Physiotherapist, the Falls Lead, and an ADOC and Registered Staff.

This order must be complied with by February 14, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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