



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 10, 2017	2017_572627_0007	035207-16, 002620-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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 4J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 2017 and March 20, 21, 22, 2017.

This Critical Incident System inspection is related to:

- Two critical incident reports the home submitted related to falls;**
- One critical incident report the home submitted related to allegations of abuse to a resident, and;**
- One critical incident report the home submitted related to allegations of abuse from a visitor to a resident.**

A Follow Up Inspection #2017_572627_0006 and a Complaint Inspection #2017_572627_0005 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), family members and residents.

The Inspector also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, internal investigations, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #627 reviewed a critical incident (CI) report submitted to the Director. The CI report described allegations of negligent care toward resident #004, and that the family of resident #004 felt the home had been neglectful when the resident became ill.

A review by Inspector #627 of resident #004's electronic progress notes revealed an entry indicating a conversation between resident #004's family and a staff member; a family member stated they felt the home had been neglectful, and that the staff member encouraged the family to discuss this with the ADOC.

Inspector #627 reviewed the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences", last revised April 2016, which was in effect at the time of the incident. The policy advised that in cases where there are allegations of abuse or neglect, Management was to ensure they immediately reported the allegation to the Ministry of Health and Long Term Care (MOHLTC).

During an interview with the Inspector, the DOC confirmed that they had had a conversation with the family, whereby a family member had made allegations of neglect of resident #004, however this was only reported to the Director on the following day. [s. 24. (1)]

Issued on this 12th day of April, 2017

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



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Original report signed by the inspector.