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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 18, 2022	
Inspection Number: 2022-1068-0001	
Inspection Type: District Initiated	
Licensee: Better Life LTC Inc.	
Long Term Care Home and City: Maple Villa Long Term Care Centre, Burlington	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2022.11.18 15:24:52 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 14-15, 2022

The following intake(s) were inspected:

- Intake: #00013552 related to infection prevention and control

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

Infection Prevention and Control
Food, Nutrition and Hydration

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary:
The Director of Care (DOC) reported that they were the home's IPAC lead, and they received assistance from the Administrative Assistant/Co-IPAC lead. They acknowledged that their primary responsibility was in the position of the DOC, and that IPAC was not their primary focus.

The residents were placed at low risk for the transmission of infection when the designated IPAC lead's primary responsibility was not the home's IPAC program.

Sources: IPAC lead job description; interview with the DOC/IPAC lead, Administrative Assistant/Co-IPAC lead and others.
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WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.

The licensee has failed to ensure that three residents were served course by course during the lunch meal service.

Rationale and Summary
Three residents were served soup on the same divided plate as their main entrée during an observation of the lunch meal.

The Food Service Manager (FSM) stated that all residents were to be served course by course, unless otherwise stated in their care plan.

The residents' care plans did not identify that they were not to be served course by course, as confirmed by the FSM.

Sources: Observations; resident clinical records; interview with the FSM.
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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The licensee has failed to ensure that the designated infection prevention and control lead worked regularly in that position onsite at the home for at least 26.25 hours per week in a home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary:
The DOC reported that they were the home's IPAC lead, and they received assistance from the Administrative Assistant/Co-IPAC lead. The DOC reported that they spent approximately five hours per week working in the role of the IPAC lead (more in an outbreak), and the Administrative Assistant/Co-IPAC lead reported that they worked approximately 15 hours per week in their role as the Co-IPAC lead.

Neither the DOC, who the home reported was their designated IPAC lead, or the Co-IPAC lead met the required 26.25 hours per week in the role of the IPAC lead for a home of their size.

There was risk that the IPAC lead would be unable to fulfill their duties and responsibilities when they did not work regularly in that position onsite for at least 26.25 hours per week.

Sources: IPAC lead job description; interviews with the Administrator, DOC/IPAC lead and Administrative Assistant/Co-IPAC lead.
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