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

Original Public Report

Report Issue Date: May 5, 2023	
Inspection Number: 2023-1068-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Better Life LTC Inc.	
Long Term Care Home and City: Maple Villa Long Term Care Centre, Burlington	
Lead Inspector Daria Trzos (561)	**Inspector Digital Signature** Daria Trzos Digitally signed by Daria Trzos Date: 2023.06.06 09:40:58 -04'00'
Additional Inspector(s) Carla Meyer (740860)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 3, 4, 8, 9, 10, 11, 12, 2023.

The following intake(s) were inspected:

- Intake: #00086656 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

Non-compliance with: FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the home's policy on the Prevention of Abuse and Neglect was not posted on any information board throughout the home. A commitment statement was located on the information board at the back entrance used by both staff and visitors stating that a copy of the Abuse and Neglect policy can be obtained by contacting the Administrator.

The Director of Care (DOC) acknowledged that the Abuse and Neglect policy was posted on the home's website.

On May 8th, 2023, a copy of the home's Abuse and Neglect policy was posted at the back entrance information board.

Sources: Observations; and interview with DOC.
[740860]

Date Remedy Implemented: May 8, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 19

Non-compliance with: O. Reg. 246/22, s.19

The licensee has failed to ensure that windows in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimeters.

Rationale and Summary
The home's policy titled, "Environmental Safety Measures," stated that all windows that are accessible to residents will have a screen and that these same windows are not able to be opened more than 15 centimeters for resident safety.

On May 3rd, 2023, a total of nine windows in the home were observed to be hopper type windows with hinges along the bottom, which opened inwards. During measurement of its opening by the Maintenance Coordinator, it was noted that there was a chain link present at the top of the window opening to prevent it from opening greater than 15 centimeters (cm), and the screen was removed. Upon further inspection of the remaining hopper windows in the home with inspector #561, one window was observed to have the chain link broken which allowed the window to open greater than 15 cm inwards; the screen was present for this window. Six of the nine hopper windows had one or both of their screens removed, some windows were screwed shut, and a couple had duct tape around its edges. One hopper window had a chain link present but was secured with a string.

The Maintenance Coordinator acknowledged the missing screens and informed inspectors that this was in preparation for the installation of portable air conditioning units which was to occur in the following week. They acknowledged the broken chains and one chain that was being secured by a string. They also stated that some windows were screwed shut during the winter months to prevent drafts.

On May 4th, 2023, two rooms with hopper windows had the air conditioning unit installed and windows were secured. All missing screens were replaced, and two broken chains were fixed.

By not ensuring the windows accessible to residents had screens and properly maintained to ensure that they did not open greater than 15 centimeters, placed residents safety at risk.

Sources: Observations; interview with Maintenance Coordinator and Administrator; review of the home's policy titled, "Environmental Safety Measures," last revised March 2022, and Maintenance Audit records.

[740860]

Date Remedy Implemented: May 4, 2023

WRITTEN NOTIFICATION: Standards and requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (3)

Non-compliance with: FLTCA, 2021, s. 23 (3)

The licensee has failed to comply with their Infection Prevention and Control policy related to measures to prevent the transmission of infections.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or this regulation requires the licensee to put in place any program, the licensee is required to ensure that the program is complied with.

Specifically, the home did not follow their policy titled "Management of VRE positive residents" in their infection control program, when a resident was not re-tested and monitored for Vancomycin-Resistant Enterococci (VRE) prior to discontinuing VRE precautions.

Rationale and Summary
The home's policy stated that for residents colonized with an identified infection, barrier precautions will be implemented. The policy outlined the criteria for discontinuing precautions and stated that residents who were infected or colonized may be removed from precautions when negative results had been obtained on at least three consecutive cultures one or more weeks apart. It further stated that once the resident has been removed from precautions, that they should be monitored once per month for four months.

A resident's clinical records indicated that they had tested positive for an infection. Their diagnosis also indicated that they had resistance to a treatment and required additional precautions as per their care plan. A registered practical nurse (RPN) confirmed that the resident remained on the unit's tracking sheet.

An observation of the resident's room showed no additional precautions in place such as signage, or additional personal protective equipment available. A single commode was present in the resident's washroom which PSWs confirmed was shared between the two residents, and that it was cleaned or disinfected after each use.

No clinical records were provided or found to indicate that the resident was re-tested or monitored for four months to support the discontinuation of precautions as per the home's policy.

By not following the home's policy for re-testing and monitoring the resident, there was low risk of transmission of infection.

Sources: Observations; resident's clinical records; the home's policy titled "Management of VRE positive residents," last revised June 2018; and interview with the DOC, IPAC Lead, and other staff.
[740860]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that actions taken with respect to residents under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
Two residents were assessed to be at high nutritional risk. PSW staff were required to document how much of the food intake the residents consumed at each meal and snack. The POC tasks were reviewed for both residents and indicated that the food intake was not always documented.

Failing to document the amount of food intake, may have increased the risk of inappropriately monitoring residents' nutritional needs.

Sources: Residents' clinical records; review of home's policy Food and Fluid monitoring intake (revised January 2018); interview with staff.
[561]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

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

The licensee has failed to ensure that there was a designated infection prevention and control (IPAC) lead who worked regularly in that position on site at the home, with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary
The DOC confirmed that the IPAC Lead was currently in the process of transitioning into the role and has not fully taken on the duties and responsibilities of that role. The DOC also stated that they were currently completing the tasks related to IPAC and confirmed that they were not meeting the required 26.25 hours per week that was required to be designated to the role.

By not having a designated person completing the required hours of the IPAC Lead, there was a risk that the tasks related to the IPAC program were not being completed.

Sources: Interview with the DOC and IPAC Lead; review of the home's IPAC Lead job description.
[740860]

WRITTEN NOTIFICATION: Quality Improvement

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (5)

The licensee has failed to ensure that within three months of the coming into force of this section, that they prepared an interim report for the 2022-2023 fiscal year.

Rationale and Summary
Inspector #561 viewed the home’s website and identified that the interim report was not posted on their website. The Administrator and the DOC stated that they had not completed the interim report for the 2022-2023 fiscal year.

Sources: Home's website; interview with DOC and the Administrator.
[561]