Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date July 8, 2022
Inspection Number 2022_1497_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Maxville Manor

Long-Term Care Home and City
Maxville Manor, Maxville

Lead Inspector
Lisa Cummings [756]

Inspector Digital Signature
Lisa Cummings
Digitally signed by Lisa Cummings
Date: 2022.07.13 15:55:44 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 2022.

The following intake(s) were inspected:

- Intake # 001695-22 (CIS # 3000-000004-22) related to medication administration
- Intake # 019494-21 (CIS # 3000-000017-21) and Intake # 019235-21 (CIS # 3000-000015-21) related to a fall that caused injury and required a transfer to hospital
- Intake # 018318-21 (CIS # 3000-000014-21) related to an allegation of resident to resident physical abuse
- Intake # 017205-21 (CIS # 3000-000013-21) related to an allegation of resident to resident sexual abuse
- Intake # 020005-21 Follow-up for compliance order (CO) #001 issued under inspection report # 2021_548756_0019 related to LTCHA s. 19 (1) with a compliance due date of February 28, 2022

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 19 (1)	2021_548756_0019	001	Lisa Cummings (756)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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

Non-compliance with: O. Reg. 79/10, s. 131 (1)

The licensee has failed to ensure that only medication prescribed for a resident was administered.

Rationale and Summary

Progress notes by an RPN and an RN detailed that the resident was administered a medication in error by a student.

When interviewed, the RPN stated they supervised the student prepare medication for another resident and then were called away. During that time, the student administered the medication to the resident who did not have a prescription for this medication. As a result of this action, the resident required additional monitoring and intervention for effects of the medication and a transfer to hospital for additional intervention.

Sources: Progress notes, interviews with an RPN and an RN.

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

Non-compliance with: FLTCA, 2021 s. 28 (1) (2)

The licensee has failed to ensure that the Director was notified of an incident of resident to resident sexual abuse.

Rationale and Summary

An RPN documented that two residents had an interaction in a resident home area hallway. When interviewed, the RPN stated the residents didn't require intervention as they separated independently.

The DOC confirmed they were not informed of this incident and became aware of it when reviewing progress notes after another incident at a later date. The DOC confirmed this incident would meet the criteria for sexual abuse and should have been reported to the Director.

Failure to report and investigate this incident caused a potential increase in risk to the residents as interventions were not put in place to prevent sexual abuse from reoccurring.

Sources: Progress notes, interviews with the DOC and an RPN.

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NC#03 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 there was an infection prevention and control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary

When interviewed, the DOC indicated they continued to fulfill the IPAC lead role while the licensee recruited for this position.

Twelve days later, the DOC remained in the IPAC lead role and confirmed that no other staff member in the home had the primary responsibility of the IPAC program. They indicated that the position of IPAC lead had been filled and the new employee would be starting the following week.

Lack of an IPAC lead who had the primary responsibility of the IPAC program could increase the risk of disease transmission for residents and staff.

Sources: Interviews with the DOC.

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NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 272*

The licensee has failed to ensure that medical masks were worn in resident areas as required by Directive #3 from the Chief Medical Officer of Health.

Rationale and Summary

A staff member was observed on their break in the town square area of the home. The staff member was seated directly behind residents who were in the same area for an activity. The staff member had their medical mask removed and was within two meters of a resident. On the same day, a team meeting was observed in a resident home area dining room. Two staff members in the meeting were observed to have their medical masks removed. There was one resident in the dining room for the meeting, and residents were on the other side of the half wall outside of the dining room.

A further observation was conducted in which a PSW was observed in a resident home area with their medical mask pulled under their chin while seated beside a resident. The Unit Manager was informed of this observation and intervened immediately.

Another observation was conducted in which an RPN was observed exiting a resident room with their medical mask pulled under their chin. The RPN pulled up their mask independently when they noticed the inspector in the hallway.

The DOC confirmed that the PSW and the RPN should have been wearing the medical mask in these situations. The DOC stated that the town square is a mixed use space for resident activities and staff breaks and that staff should ensure a two meter distance when resident activities are occurring. The DOC also stated that staff should only remove their medical mask when taking a sip from a drink during a team meeting on a resident home area and don the medical mask again when finished.

Failure to properly wear a medical mask when on a resident home area and when within two meters of a resident increased the risk of disease transmission.

Sources: Observations of the town square and of resident home areas, interviews with the DOC and other staff.

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