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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 16, 2023
Inspection Number: 2023-1497-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

Lead Inspector	**Inspector Digital Signature**
Lisa Cummings (756)	Lisa Cummings Digitally signed by Lisa Cummings Date: 2023.08.23 15:19:08 -04'00'

Additional Inspector(s)
Laurie Marshall (742466)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19, 20, 21, 22, 23, 26, 28, 29, 30, 2023 and July 4, 5, 2023
The inspection occurred offsite on the following date(s): June 27, 2023 and July 6, 7, 2023

The following intake(s) were inspected:

- Intake: #00090219 - Proactive Compliance Inspection for Maxville Manor.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
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
Pain Management
Falls Prevention and Management

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)

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

Upon observation of the bulletin board of required documents that were to be posted in the home, the policy to promote zero tolerance of abuse and neglect of residents was not posted. The Director of Care (DOC) stated the policy had been posted on this board previously and they were not aware it was removed. The policy was posted prior to the end of the inspection.

Sources: Observation of the home, interview with the DOC.

[756]

Date Remedy Implemented: June 29, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that their visitor policy was posted in the home.

Upon observation of the bulletin board of required documents that were to be posted in the home, the visitor policy was not posted. The DOC stated the policy had been posted on this board previously and they were not aware it was removed. The policy was posted prior to the end of the inspection.

Sources: Observation of the home, interview with the DOC.

[756]

Date Remedy Implemented: June 29, 2023

WRITTEN NOTIFICATION: Dietary Services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (1) (a)

The licensee has failed to ensure that the organized program of nutritional care and dietary services was evaluated and updated annually.

Rationale and Summary
In accordance with FLTCA s. 15 (1) (a) the licensee shall have an organized program of nutritional care and dietary services to meet the daily nutritional needs of the residents, and in accordance with O. Reg. 246/22 s. 34 (1) 3. the program must be evaluated and updated annually in accordance with evidence-based practices.

The Registered Dietitian provided policies that were specific to their role and these had been evaluated two years prior. All other policies provided in the Food Services Policy and Procedures Manual were dated thirteen years prior.

The Director of Food Services stated they were unable to find documentation of a yearly evaluation and update of the nutritional care and dietary services program.

Failing to evaluate and update the food services policies and procedures annually may have resulted in outdated or inconsistent practices that increased the risk to resident health.

Sources: Food Services Policy and Procedures Manual, Policies: Referrals, House diets, Diet Orders, Small

and Large Portions, Table Setting, and Dysphagia Management, interviews with the Registered Dietitian and the Director of Food Services.

[756]

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #004 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 has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control (IPAC) program.

Rationale and Summary
In accordance with FLTCA, 2021, s. 23 (4) the licensee shall ensure there is an IPAC lead whose primary responsibility is the IPAC program and in accordance with O. Reg. 246/22 s. 102 (15) 2. the IPAC lead must work onsite for 26.25 hours per week.

The Director of Care stated they did not currently have an IPAC Lead and the Assistant Director of Care (ADOC) was covering this role in the interim. The ADOC has been dedicating twenty hours per week to the IPAC lead role, with an additional four hours dedicated to IPAC self-audits completed by another staff member.

Failing to have an IPAC lead whose primary responsibility was the IPAC program working the required number of hours could have increased the risk of infectious disease transmission.

Sources: ADOC schedule, IPAC lead job description, interview with the DOC.

[756]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to comply with the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, regarding masking.

Rationale and Summary
The Minister's Directive indicated that licensees were required to ensure that the masking requirements set out in the COVID-19 guidance document for Long-Term Care Homes in Ontario were followed. The guidance document described that all staff, students, and volunteers must wear a surgical mask for the entire duration of their shift indoors and that masks must not be removed in designated resident areas.

During the shift report on a resident home area, four staff members participating in the meeting were observed to have lowered their masks under their chin or removed their mask. The shift report meeting was taking place in the resident dining room which was open to the resident home area.

The DOC stated staff members were allowed to remove their masks to have a drink, but other than this their masks should be donned when on a resident home area.

Failing to wear a mask in designated resident areas posed a risk to residents related to the potential for transmission of infectious disease.

Sources: Observation on a resident home area, interviews with the DOC.

[756]

WRITTEN NOTIFICATION: Doors in a home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the clean utility room and the wheelchair services room on a resident home area were kept closed and locked.

Rationale and Summary
The clean utility room and the wheelchair services room doors on a resident home area were both found to be ajar and unlocked. The two rooms were identified by signs on the doors as non-resident areas that required the door to be kept locked.

The Director of Environmental Services was informed of the observation. They stated the doors should be closed and locked and they would have a maintenance staff member repair them.

Sources: Observations of the clean utility room and wheelchair services rooms, interview with the Director of Environmental Services.

[756]

WRITTEN NOTIFICATION: Required Programs: Falls prevention

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the falls prevention and management program was evaluated and updated annually.

Rationale and Summary
In accordance with s. 34 (1) (3) the licensee shall ensure that the program shall be evaluated, and updated annually in accordance with evidence-based practices and if there none, in accordance with prevailing practices.

Review of the homes Nursing Services Policy and Procedure Manual for Falls Management last revision date was two years prior.

Interview with the DOC confirmed that the falls policies had not been revised or updated annually.

Sources: Nursing Services Policy and Procedure Manual for Falls Management, interview with the DOC.

[742466]

WRITTEN NOTIFICATION: Required Programs- Skin and Wound Care Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to ensure that the skin and wound care program was evaluated and updated annually.

Rationale and Summary

In accordance with O. Reg. 246/22 s. 34 (1) (3) the licensee shall ensure that the program shall be evaluated and updated annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.

Review of the homes Nursing Services Policy and Procedure Skin and Wound care Management last revision date was eight years prior.

Interview with the DOC confirmed that the skin and wound care program and policies had not been revised or updated annually.

Sources: Nursing Services Policy and Procedure Manual for Skin and Wound Care Management; interview with the DOC.

[742466]

WRITTEN NOTIFICATION: Required Programs: Pain Management Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The licensee has failed to ensure that the Pain management program was evaluated and updated annually.

Rationale and Summary
In accordance with O. Reg. 246/22 s. 34 (1) (3) the licensee shall ensure that the program shall be evaluated and updated annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.

Review of the homes Nursing Services Policy and Procedure Manual for Pain Management last revision date was thirteen years prior.

Interview with the DOC confirmed that the pain management program policies had not been revised or updated annually.

Sources: Nursing Services Policy and Procedure Manual for Pain Management; interview with the DOC.

[742466]

WRITTEN NOTIFICATION: Housekeeping

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that high-touch surfaces were disinfected more than once a day during a COVID-19 outbreak on a resident home area, in accordance with evidence based practices.

Rationale and Summary
The Public Health Ontario (PHO) document titled 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in Health Care Settings', indicated that high-touch surfaces in outbreak areas should be cleaned and disinfected more frequently than once a day using a low level disinfectant.

A resident home area was experiencing a COVID-19 outbreak during the course of the inspection. Two Housekeepers stated they disinfected high-touch surfaces in this outbreak area once a day and were unable to disinfect the high-touch surfaces more often. The Director of Environmental Services stated the expectation in the home was that housekeepers disinfect high-touch surfaces two to three times a day in outbreak areas.

Failing to disinfect high-touch surfaces in a COVID-19 outbreak area more frequently than once a day increased the risk of infectious disease transmission.

Sources: PHO document 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in Health Care Settings; interviews with Housekeepers and the Director of Environmental Services.

[756]

WRITTEN NOTIFICATION: Hazardous Substances

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee has failed to ensure that a hazardous substance was kept inaccessible to residents at all times.

Rationale and Summary
An open and uncapped bottle of the Arjo 'All-Purpose Disinfectant Cleaner' was observed on the floor of a tub room. A Personal Support Worker (PSW) identified that this product was normally used with the sprayer of the tub, however they noted the sprayer did not always work and therefore they were using the product directly from the bottle. The PSW stated the opened bottle was kept on the tub room floor as residents did not have access to the area without a staff member present. The Director of Environmental Services was notified of the open bottle in the tub room on the same day and they identified that this product should be connected to the tub and only be used with the sprayer attachment.

The following day, the tub room was observed with the door left open and unattended with a wet floor sign in the doorway. The open bottle of the Arjo 'All-Purpose Disinfectant Cleaner' remained on the floor of the tub room while residents were seated in the dining room close by.

Failing to keep the Arjo 'All-Purpose Disinfectant Cleaner' inaccessible created a risk to residents.

Sources: Observations of a tub room, interviews with a PSW and the Director of Environmental Services.

[756]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure implementation of a standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
Specifically, the licensee failed to ensure implementation of the Infection Prevention and Control (IPAC) Standard sections 10.4 (h) and (i) which stated that residents are supported to perform hand hygiene prior to receiving meals and snacks, including residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

A resident home area was observed during a meal service. All residents were observed entering the

dining room, which included six residents who entered the dining room independently and three residents who were assisted from a lounge area. None of the residents were observed to be assisted with hand hygiene prior to the meal service.

The DOC stated residents are supposed to receive assistance with hand hygiene at meal service and they have disposable washcloths at each dining room entrances to complete this task.

Failing to assist residents with hand hygiene prior to a meal increased the risk of infectious disease transmission.

Sources: Observation of a meal service, interview with the DOC.

[756]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (iv)

The licensee has failed to ensure that the storing of a medication after opening was in compliance with the manufacturers instructions.

Rationale and Summary
During the shift change medication count in a medication room, a medication was observed to be removed from a locked bag and was counted. It was observed that there were two vials of this medication; one had an unopened sealed top, and the other had been opened. Both vials of this medication were included in the narcotic count.

Review of the manufacturer's instructions for this medication indicated that the product should be discarded within 28 days of initial use. Further, communication with the Pharmacist regarding drug stability confirmed that the medication supplied can only be kept for 28 days once opened and then must then be discarded. The Pharmacist confirmed they did not give direction to keep an open vial for reuse and this vial should be discarded.

The Homes Narcotic Control Policy stated that any remaining waste in the vial must also be locked in the narcotic box of the med cart until such time as a second registered staff is available to witness the remaining waste.

A Registered Nurse and a Registered Practical Nurse were conducting the shift count. The RN reported that the opened medication vial was not discarded because of an ongoing medication shortage and was kept for re-use. However, the DOC reported that they had not received direction from pharmacy to keep opened medications for later use.

Failure to follow manufacturer's instructions regarding storage and disposal of a medication posed moderate risk, as residents may receive expired medications.

Sources: Observations; Narcotic Control Policy; Manufacturer's instructions; Email Communication from the Pharmacist; Interviews with an RN, the DOC and the Pharmacist.

[742466]

COMPLIANCE ORDER CO #001 Packaging of Drugs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 135

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review and update the licensee's medication policies to ensure that drugs remain in the original labelled container or package supplied by the pharmacy service provider until administered to a resident or destroyed.

2. Provide training to all registered nursing staff relating to safe storage of drugs, specifically injectable high-risk medications including opioids (but not limited to all medications deemed high risk) and their safe disposal.

3. The training required under step (2) must:

i. Include content that is provided by, or approved by, a pharmacy service provider; and,
ii. Address considerations of injectable medications via subcutaneous administration of opioids that are regularly scheduled; and,
iii. Implement registered nursing staff training regarding safe storage of drugs to ensure drugs remain in the original package or container provided by the pharmacy service provider until administered to a resident or destroyed.

4. Develop and complete medication audits (which include documenting remedial action if errors are identified in medication practices) specifically relating to injectable medications, to ensure that medications remain in their original packaging until the time of administration by registered nursing staff or destroyed. The audits will be completed weekly on the day, evening, and night shift on all resident home areas, until consistent compliance is achieved.

A written record must be kept of everything required under step (1), (2), (3) and (4) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy until administered to a resident or destroyed.

Rationale and Summary
An RN was observed removing a pre-drawn syringe out of the medication cart in the medication room which was labelled with the medication name and a resident's name. The RN then administered this syringe of medication to the resident.

The Narcotic Control Policy stated that for residents who receive more than one dose of the same controlled substance on any given shift, the registered staff member can draw up two or more doses from the same vial to reduce waste.

The RN reported that subcutaneous medication is pre-drawn for the resident with the previous shift's registered nursing staff at shift change. The RN reported that the waste from the medication pre-drawn syringes was left in two additional syringes, labelled as medication waste, and would be counted and wasted with the oncoming registered nursing staff. The RPN reported that narcotic injections for residents were prepared at the start of their shift for residents who required regular injections. The RPN identified the medication pre-drawing was based on the nurses' preference.

Review of the pharmacy's quarterly report of medication incidents identified that there was a medication omission as a syringe of a narcotic was found in a drawer and was not identified as a narcotic dose administered or as narcotic waste. The Pharmacist reported that they were not in agreement with pre-drawing medication because if there were changes to medication there was a risk those medications may be overlooked or the doses could be missed.

The DOC confirmed that staff were drawing up medication and keeping them in the narcotic box in the medication cart.

There is an increased risk of errors in administration of a controlled substance when it is removed from the original labelled container provided by the pharmacy prior to the time of administration or destruction.

Sources: Observations; Narcotic Control Policy, Medical Arts Pharmacy Quarterly Report of Medication Incidents; Interviews with an RPN, an RN, the DOC and the Pharmacist.

[742466]

This order must be complied with by October 16, 2023

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.