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

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Original Public Report

Report Issue Date: October 18, 2024
Inspection Number: 2024-1497-0006
Inspection Type: Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24 -27, 2024, October 1 - 4, 2024, October 7 - 11, 2024 and October 15 -16, 2024

The following intake(s) were inspected:

- Intake: #00119448 - related to alleged staff to resident abuse.
- Intake: #00121403 - related to a fall which resulted in an injury.
- Intake: #00123731 - related to an environmental hazard.
- Intake: #00125932 - related to alleged resident to resident abuse.
- Intake: #00127044 - related to alleged resident to resident abuse.

The following Inspection Protocols were used during this inspection:

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
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)
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches to care, including behavioral triggers that may result in a resident's responsive behaviors were developed.

Sources: Written plan of care, interview with Personal Support Workers (PSW) and a Registered Nurse (RN).

The licensee added the behavioral triggers to the resident's written plan of care prior to the conclusion of the inspection.

Date Remedy Implemented: October 4, 2024

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (1)
Infection prevention and control program
s. 23 (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

The licensee has failed to comply with the home's infection prevention and control program, specifically by not using the Personal Protective Equipment Audit tool mentioned in the home's Personal Protective Equipment policy.

In accordance with O. Reg 246/22 s. 11 (1) b, where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program is complied with. Specifically, the home's Personal Protective Equipment Policy - IC 03-07, last reviewed on October 18, 2023, stated "Use the Personal Protective Equipment Audit on Surge QRM to collect information with respect to compliance with PPE practices and report to the Infection Prevent and Control (IPAC) Committee as per the home's quality reporting structure."

Sources: Review of Personal Protective Equipment policy (Policy #: IC 03-07), last reviewed October 18, 2023, interview with the Director of Care (DOC) and Infection Prevention and Control (IPAC) Lead.

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The licensee has failed to ensure that a Personal Support Worker (PSW), who provided direct care to residents, received, as a condition of continuing to have contact with residents, annual training in the area of abuse recognition and prevention.

Sources: PSW's education / training record, interview with the Director of staff development.

WRITTEN NOTIFICATION: Police notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 105
Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. Specifically, when a Personal Support Worker yelled and forcefully held a resident's arm, the licensee reported this incident as alleged physical and verbal abuse but did not notify the appropriate police service.

Sources: Critical incident report, internal investigation notes, interview with the Director of Care.