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: December 13, 2022	
Inspection Number: 2022-1058-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Maynard Nursing Home, Toronto	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2022.12.21 23:03:34 -05'00'
Additional Inspector(s) Julie Ann Hing (649)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 19-21, 24-28, and November 1-2, 2022.

The following intake(s) were inspected:

- Intake: #00011525-Maynard LTC Proactive Compliance Inspection

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

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

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)
O.Reg. 246/22, s. 138 (1) (a) (iv)

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs.

Rationale and Summary:
During observation of the medication room, there were different types of expired drugs sealed in their original containers. These medications were immediately removed from the shelf by the nurse. The nurse and Director of Care (DOC) acknowledged that the government stock drugs were audited monthly and that records were not kept of these audits.

There was minimum risk as these medications did not reach the residents.

Sources: Observation of storage areas in the medication room, interviews with Registered Nurse (RN) #113, and other staff. (698)

Date Remedy Implemented: October 20, 2022

WRITTEN NOTIFICATION: Windows

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents had a screen and cannot be opened more than 15 centimeters.

Rationale and Summary:
During a tour of the home with the Director of Environmental Services (DES) advised that the window opening in a resident's measured 45.72 centimeters (cm) and the window screen was broken.

Window opening in residents' room exceeding the required opening of 15 cm along with a broken screen put residents at risk for eloping.

Sources: Observation on October 20, 2022, at 1021 hours of window opening in residents' room #16 measured 45.72 cm by the DES and broken window screen. [649]

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)
NC #003 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 that IPAC self-audits were completed at a minimum of every two weeks when not in a Coronavirus (COVID-19) outbreak, and at a minimum of once a week when the long-term care home was in an outbreak.

According to the Ministry of Long-Term Care (MLTC) COVID-19 Guidance document for Long-Term Care Home (LTCH) in Ontario IPAC self-audits must be completed at a minimum of every two weeks unless when in an outbreak, it must be completed at a minimum of weekly.

Rationale and Summary:
IPAC self-audits were not completed at the required frequency of every two weeks. Specifically, were not completed on two separate dates in August and September 2022, when the home was not in outbreak.

Failure of the home to complete IPAC self-audits at the required frequency, increased the risk of IPAC practice concerns not being identified in a timely manner.

Sources: IPAC self-assessment audits, interviews with IPAC lead, and other relevant staff. [649]

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15)

The licensee has failed to ensure that the IPAC lead worked the required hours.

Rationale and Summary:

The Infection Prevention and Control (IPAC) lead advised that they alternate IPAC hours between 22.5 and 15 hours every other week based on the home's current occupancy numbers rather than the licensed bed capacity. They acknowledged falling short of the required 26.25 hours per week based on the legislative requirements for the size of home.

Failure of the home to ensure that the IPAC lead worked the required legislative hours increased the risk of not meeting the IPAC requirements.

Sources: Interviews with IPAC lead. [649]

WRITTEN NOTIFICATION: Training and Orientation
NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 259 (2)

The licensee has failed to ensure that newly hired staff received training in all eight required topics for infection prevention and control under paragraph 9 of subsection 82 (2) of the Act.

Rationale and Summary:

IPAC training records were randomly selected and reviewed for two newly hired staff. The IPAC lead acknowledged that both staff members had not completed training on all eight required IPAC topics.

Failure of the home to ensure that newly hired staff completed IPAC training in all eight required IPAC topics increased the risk of new staff not following IPAC practices.

Sources: Review of training records for two newly hired staff and interviews with IPAC lead and other relevant staff. [649]

WRITTEN NOTIFICATION: Dining and Snack service
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that no residents who requires assistance with eating or drinking were served a meal until someone was available to provide assistance to three residents.

Rationale and Summary:
(i) The first resident's lunch tray was observed on a table during tray service.

According to the resident's care plan they required total assistance with meals.

A PSW advised that they usually feed the resident last. They explained that they had provided assistance to another resident and had left the resident's lunch tray. They acknowledged that the lunch tray should not have been served to the resident until there was someone available to provide the resident with assistance.

Leaving a resident's lunch tray unattended in their presence poses the risk of refusal.

Sources: Observation of the resident's lunch meal service, review of the resident's care plan, interviews with the PSW, and other relevant staff. [649]

Rationale and Summary:
(ii) A second PSW went to assist one resident with their meal while the meal cart with a second resident's lunch meal remained outside in the hallway. After the PSW was finished, they went on to assist the second resident whose meal tray was on the cart.

The PSW advised that the previous resident was a quick eater and acknowledged that the second resident's lunch meal was not served and left in the cart, while they had assisted the previous resident.

Sources: Observations of lunch meal service, interviews with the PSW and other relevant staff. [649]

Rationale and Summary:
(iii) A third resident's lunch tray was observed sitting on a cart in the dining room for a couple of minutes before it was served to the resident.

Failure to ensure that foods and fluids were stored and served to residents at temperatures that were safe and palatable increase the risk of bacteria growth when out of identified range.

Sources: Observations of lunch meal service, interview with the PSW and other relevant staff. [649]

WRITTEN NOTIFICATION: Dining and Snack service
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 5.

The licensee has failed to comply with their food temperature control policy for suggested temperatures of food at point of service. In accordance with O. Reg 246/22, s. 11. (1) (b), the food service team members were required to check the food temperatures daily: prior to point of service and at the end of service. Any food found below the optimum temperature should be reheated to an acceptable temperature.

Rationale and Summary:
Specifically, staff did not comply with the home's food temperature control policy that required food service team members to check the food temperature before and after the meal.

The service and delivery worksheet for the lunch meal service on one of the home areas was reviewed with a Dietary Aide (DA). They acknowledged that they had not followed the home's policy of taking the temperature after the meal.

Failure to take the temperature after the meal service pose the risk of food being served to residents at a temperature that was both unsafe and not palatable.

Sources: Observation of lunch meal service, review of home's Food temperature control policy, interview with DA and other relevant staff. [649]

WRITTEN NOTIFICATION: Family Council
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7)

The licensee has failed to ensure that the home on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council (FC); and convene semi-annual meetings to advise such persons of the right to establish a FC.

Rationale and Summary
The home did not have a FC since 2018. The General Manager (GM) indicated that there were no records of communication to family members, or persons of importance to residents, regarding their right to establish a FC in the home. No meetings were held with family members regarding establishing a FC between 2018 to the time of the inspection in October 2022.

According to the Fixing Long-Term Care Act, 2021, FLTCA, 2021, s. 65 (7), the home was required, on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a FC; and convene semi-annual meetings to advise such persons of the right to establish a FC.

Sources: Family Council policy #15-01, Continuous Quality Improvement Initiative report, Resident and Family/Caregiver Experience Survey, Residents' Council meeting minutes; Interviews with Manager of Recreation Services, family member and the GM. [698]

WRITTEN NOTIFICATION: Annual Evaluation
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 125 (1)

The Licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
The home was unable to provide any evidence of this practice occurring in the home. According to Professional Advisory Committee (PAC) meeting minutes, quarterly and annual meetings were not done in over 20 months.

The home's failure to have an interdisciplinary team review at least annually of the effectiveness of the home's medication management system poses the risk of changes and improvements not being implemented.

Sources: Review of the home's PAC meeting minutes on February 26, 2021, and interview with DOC. [698]

COMPLIANCE ORDER CO #001: Plan of Care
NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

The licensee shall:
(1) Update the beverage serving sheet to indicate that the first resident was on fluid restrictions.
(2) Retrain three staff, PSW, DA, RPN, on the capacity of different cups and soup bowl sizes used in the home.
(3) Provide education to all PSWs and registered staff currently working with the first resident to ensure they are kept aware of the resident's fluid restriction.

(4) Maintain a record of the training provided, included the date, who conducted the training, and name of staff who attended the training.
(5) Conduct audits of the first resident's fluid intake for a period of three weeks following the service of this order.
(6) Maintain a record of the audits, including the date, who conducted the audit, staff audited, results of each audit and actions taken in response to the audit findings.
(7) Update the dietary serving sheet in the basement dining room to include the second resident's dietary and fluid requirements.
(8) Provide education to all the PSWs currently working with the second resident to ensure they are kept aware of the resident's dietary requirements.
(9) Maintain a record of the training provided, included the date, who conducted the training, and name of staff who attended the training.
(10) Conduct audits of the second resident to ensure provision of the required beverage, for a period of three weeks following the service of this order.
(11) Maintain a record of the audits, including the date, who conducted the audit, staff audited, results of each audit and actions taken in response to the audit findings.

Grounds Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in two resident's plan of care was provided to the resident as specified in their plans.

Rationale and Summary:
(i) The first resident was admitted on a fluid restriction. Their plan of care indicated that they were on a daily fluid restriction.

The resident fluid intake record over a period, prior to going on a leave of absence, indicated they consumed more than their fluid restriction amount.

The resident's fluid intake record after their return from their leave of absence, over a period, indicated they consumed more than their fluid restriction amount.

A PSW, who served the resident during a lunch observation, told the inspector that they had forgotten about the resident's fluid restriction. They told the inspector that they only became aware of the resident's fluid restriction after the resident returned to the home. The PSW showed the inspector the printed snack cart list, upon review there was no mentioned of the resident's fluid restriction.

Further, the fluid capacity provided by the PSW when they served the resident, was inaccurate based on the cups and soup bowl capacity. The DA and RPN were unaware of the fluid amounts for utensils that the resident was served in.

The Registered Dietitian (RD) was not aware until after the above-mentioned observation that the resident was consistently consuming more than their daily fluid restrictions.

An RPN who monitored residents' fluid intake did not recall the resident being on their radar related to excess fluid intake.

A second RPN was aware that the resident was on a fluid restriction since their admission, but only became aware of the resident's excess fluid intake when it was brought to their attention by the inspector. When asked why this was not identified sooner, the second RPN advised that they were not serving the resident their fluids in the dining room and was only supervising and that PSWs may not be counting the soup as part of the resident's fluid intake.

Failure to provide the resident with the correct fluid amount put them at risk of receiving excess fluids and further decline in their health status.

Sources: Observation of the resident lunch meal service, review of resident's care plan, review of snack list on a home area, interviews with a PSW, DA, three RPNs, RD, and other relevant staff.

Rationale and Summary:
(ii) A second resident plan of care indicated to provide the resident with a required beverage at lunch and dinner, related to a particular diagnosis.

During lunch meal service, the resident was not provided with a required beverage, and none was available.

A PSW advised that occasionally the resident would ask for a required beverage. They advised that only a type of juice was available on the cart, which the resident did not like. There was no list on the beverage cart to indicate that the resident should have been offered their required beverage at lunch and dinner related to their diagnostic history.

Review of the meal service binder with the DA indicated there was no dietary sheet for the resident with their dietary requirements on the above-mentioned observation. In a follow-up interview the next day, they advised that the resident had been eating in a different dining room for a period and acknowledged that even though the dietary sheet had been updated, it still did not include the dietary requirements for the resident.

GM told the inspector that they placed an order for the resident's required beverage.

Failure to ensure the provision of the resident's required beverage as specified in their plan of care puts them at risk of developing a medical condition.

Sources: Observation of the resident's lunch meal service, review of resident's care plan, interview with a PSW, DA, and other relevant staff. [649]

This order must be complied with by March 14, 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.