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
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Original Public Report

Report Issue Date: April 3, 2024
Inspection Number: 2024-1497-0002
Inspection Type: Complaint Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

Lead Inspector	**Inspector Digital Signature**
Pamela Finnikin (720492)	Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2024.04.03 15:54:20 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 28-29, 2024 and March 1, 2024

The following intakes were completed in this complaint inspection:

- Intake: #00108357 related to reporting critical incidents

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00094942 related to Infection Prevention and Control
- Intake: #00101051 related to alleged resident to resident sexual abuse

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

Infection Prevention and Control

Prevention of Abuse and Neglect
Reporting and Complaints
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

While reviewing a resident's progress notes in Point Click Care (PCC), it was noted that there were four incidents of sexual abuse by a resident towards others residents between November 2023 - February 2024.

In an interview with the DOC, they confirmed that no Critical Incidents (CI) were

submitted for these incidents as required.

There was a risk that trends might not have been identified and a delay in investigation and follow up when incidents of alleged sexual abuse were not reported to the Director as required.

Sources: Record review of residents including PCC, and interview with the DOC and others.

[720492]

WRITTEN NOTIFICATION: Notification re incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary

A review of two resident progress notes in PCC for an incident occurring on a specific date in February 2024 and two resident progress notes in PCC for an

incident occurring on another specific date in February 2024, confirm there was no documentation that the SDM had been notified after a sexual abuse incident had occurred.

A review of Policy and Procedure: Zero Tolerance for Abuse and Neglect Policy #: RRD - 01 Last reviewed: 01/12/2023 confirmed that the process for investigation into any alleged sexual abuse incident includes notifying the resident's POA/designate.

An RPN confirmed in an interview that the SDM for two residents were not notified of the incident that occurred in February 2024 as required.

The DOC confirmed in an interview that the SDM is notified as part of the investigation process and this would be documented in PCC.

Failure to ensure that a resident's SDM was notified of any alleged abuse incident delayed the resident from being provided support by their SDM.

Sources: Resident's health care records including progress notes, Policy: Zero Tolerance for Abuse and Neglect RRD-01, interviews with DOC, RPN and others.

[720492]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

A Critical Incident Report was submitted in November 2023 related to an incident involving inappropriate sexual behavior by a resident towards another resident.

In November 2023, the CI was updated to indicate that the resident's plan of care was updated to reflect the interventions in place as a result of the incident.

In an interview and review of PCC by the DOC and ADOC, it was confirmed that staff failed to update the resident's plan of care including the kardex and written plan of care.

Failure to provide clear direction regarding a resident's interventions related to safety puts the resident at risk of future incidents occurring.

Sources: Resident's health care records including written plan of care, CIR, interviews with the DOC and ADOC.

[720492]

WRITTEN NOTIFICATION: Plan of Care - When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that when a resident's plan of care for responsive behaviours were no longer effective, the plan of care was reviewed and revised.

Rationale and Summary

A resident's written plan of care was updated in November 2023 to include an intervention in place for when a resident comes into contact with certain other residents on the unit.

A review of the resident's progress notes in PCC indicated that there were four incidents of sexual abuse by the resident towards other residents between November 2023 - February 2024. The progress notes also indicate multiple incidents where staff documented that the intervention did not work when an incident was occurring,

Inspector #720492 observed the resident's specific intervention on a date in March 2024. When the resident's intervention was observed by the inspector, it did not work as intended and there was a history of the intervention not working as the resident had come into contact with other residents.

An interview with an RPN confirmed that the intervention does not always work as intended.

Failure to ensure that the interventions in the resident's care plan is reviewed and

revised puts other residents at an increased safety risk.

Sources: The resident's health care records including the written plan of care, observations of the resident, interview with an RPN and others.

[720492]

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to respond to a written complaint concerning the operation of the home related to a resident as required.

Rationale and Summary
The Long-Term Care Home (LTCH) received a letter of complaint in January 2024 that outlined concerns related to the operation of the home.

The Assistant Director of Care (ADOC) sent a response letter to the complainant on the same date in January 2024.

When the response was reviewed, the home did not include the Ministry's toll-free telephone number for making complaints.

In an interview in February 2024, the ADOC confirmed that a complaint email was received in January 2024 related to operational concerns as a result of an incident involving a specific resident. This complaint email was responded to on the same date in January 2024 but did not contain all information as required.

Sources: Review of complaint and response emails and an interview with the ADOC.

[720492]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

Non-compliance with O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (e)
The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place as is required by Additional Requirement 9.1 (e) under the IPAC Standard for Long Term Care Homes, April 2022, revised September 2023.

Rationale and Summary

Inspector #720492 observed Personal Protective Equipment (PPE) outside of a resident's room. There was no point-of-care signage posted at the resident's door indicating enhanced IPAC measures to follow. When inspector inquired about isolation requirements and signage for the resident, staff on the unit stated that the resident was on isolation with contact precautions and were unsure if signage was required.

An interview with the IPAC Lead confirmed that point-of-care signage should be posted for the resident as a result of enhanced contact precautions.

Failure to ensure point-of-care signage indicating enhanced IPAC control measures are in place could lead to transmission of infection.

Sources: Observations on resident units, IPAC Standard, interview with IPAC Lead and others.

[720492]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that the Director was notified within three business days after a resident sustained an injury resulting in a transfer to the hospital with a significant change in their health condition.

Rationale and Summary

The resident was transferred to the hospital in October 2023 as a result of increased pain. In an email sent to the ADOC and DOC in January 2024, the resident's family member confirmed that the resident stated on a date in October 2023 that they had a fall the previous night.

The discharge summary was reviewed and stated that the resident was admitted as a result of an injury sustained due to a fall and received treatment as an inpatient for nine days in October 2023.

The ADOC and DOC were aware that a report would be required to be submitted to the Director within three business days of the incident. The ADOC confirmed that this incident was not reported to the Director.

Sources: Review of progress notes for the resident, complaint email and responses, and an Interview with the ADOC.

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