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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 19, 2024

Inspection Number: 2024-1058-0001

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: Maynard Nursing Home, Toronto

Lead Inspector	**Inspector Digital Signature**
Manish Patel (740841)	Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2024.04.04 09:35:28 -04'00'

Additional Inspector(s)
Nrupal Patel (000755)
Faresha Mohammed (000825) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 29, 2024 and March 1, and 4 - 7, 2024

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

- Intake #00101733 / CI #2211-000018-23, and Intake #00101997 / CI #2211-000019-23 - related to injury to the resident of unknown cause
- Intake #00102830 / CI #2211-000021-23 - related to improper care of a resident
- Intake #00106158 / CI #2211-000002-24, and Intake #00108771 / CI #2211-000005-24 - related to staff-to-resident abuse

- Intake #00109098 / CI #2211-000007-24 - related to unexpected death of a resident

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to ensure that a resident's rights to have their lifestyle and choices, specifically regarding toilet use, was respected.

Rationale and Summary:
A resident required assistance from two staff members for toileting, utilizing a mechanical device.

A resident expressed to the Personal Support Worker (PSW) that they would like to use the toilet. According to the resident, they were told by the PSW to wait until the next shift to

receive staff assistance with toileting with use of a mechanical device.

Another PSW advised being aware of resident's request to use the toilet. They informed the resident that they required the assistance of two staff members to assist them with toileting with use of the mechanical device, and that the second staff was on break. The PSW told the resident that they would return to assist them when the second staff member returned from break. The resident expressed to the inspector that the PSW did not return during that shift, and were not assisted to have a bowel movement until the next shift.

Review of Clinical records of the resident indicated that the resident was not toileted during the above shift.

The General Manager acknowledged that the resident's choice to sit on the toilet was not respected when staff failed to put them on the toilet during the above shift.

Failure to put the resident on the toilet when requested put them at risk of having to hold their bowel movement and at risk for constipation.

Sources: Resident's clinical records; Home's Investigation Notes; Interviews with resident, PSW and the General Manager.

[000755]