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: Nov. 16, 2023	
Inspection Number: 2023-1058-0003	
Inspection Type: Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Maynard Nursing Home, Toronto	
Lead Inspector Patricia McFadgen (000756)	**Inspector Digital Signature**
Additional Inspector(s) Noreen Frederick (704758)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1, 2, 3, 6, 2023

The following intake(s) were inspected in this inspection:
Intake #00096280 / Critical Incident (CI) # 2211-000012-23 - related to Falls Prevention and Management.
Intake #00099681 / CI #2211-000015-23 - related to Infection Prevention and Control.

The following intake(s) were completed in this inspection:
Intake #00088746 / CI # 2211-000008-23, Intake #00090902 / CI #2211-000011-23 - related to an injury with a significant change in condition.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Obstruction, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 153 (b)

The licensee has failed to ensure that staff members do not alter a record or other thing that has been demanded by the inspector conducting an inspection.

Rationale and Summary
The inspector reviewed the home's Infection Prevention and Control (IPAC) self- assessment audits on November 2, 2023, and noted that an audit from the week of October 16, 2023, was missing and IPAC Lead confirmed that it was not completed. On November 3, 2023, they provided an audit to the inspector dated October 17, 2023, and stated that they completed the audit on October 17, 2023.

Upon further review and discussion with IPAC lead, they admitted that they completed the self-assessment audit on November 2, 2023 and backdated to October 17, 2023. General Manager (GM) stated if the audit was not completed then the staff should have said that it was not done.

Deliberately falsification of documents misleads the inspector in carrying out the inspector's duties.

Sources: IPAC self-assessment audits, Minister's Directive: COVID-19 response measures for long-term care homes effective August 30, 2022, and interviews with IPAC Lead and other staff.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically COVID-19 outbreak.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to disease outbreak on October 17, 2023 indicated that public health declared a COVID-19

outbreak on October 17, 2023. However, Director of Care (DOC) stated that the outbreak was in-fact declared by the public health on October 16, 2023 and they made an error with the dates. They acknowledged that they did not immediately report the COVID-19 outbreak to the Director and did not contact the Ministry's method for after hours emergency.

Failure to submit CIS reports within the appropriate timeline may have resulted in the Director being unaware of the outbreak and taking necessary actions.

Sources: CIS #2211-000015-23 and interview with DOC.

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