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
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Original Public Report

Report Issue Date: November 5, 2024
Inspection Number: 2024-1058-0002
Inspection Type: Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: Maynard Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1, 2, 3, 4, 7, 8, 2024.

The following intake(s) were inspected:

- Intake: #00118105 / Critical Incident Systems (CIS) #2211-000013-24 was related to alleged abuse.
- Intake: #00119509 / CIS #2211-000016-24 was related to alleged neglect and skin and wound care.
- Intake: #00120439 / CIS #2211-000017-24 was related to falls.
- Intake: #00127767 / CIS #2211-000022-24 was related to COVID-19 outbreak.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately report the written complaint received that concerned lack of care of a resident to the Director.

Rationale and Summary
The licensee received a written complaint from a resident's Power of Attorney (POA) alleging concerns about the lack of care provided by staff.

A Critical Incident System (CIS) report was submitted to Ministry of Long-Term Care (MLTC).

The Director of Care (DOC) indicated that they should have called the Service

Ontario After-Hours Line to report the complaint.

This impacted the resident's rights to legislative process and increased their risk for lack of care consistent with their needs.

Sources: CIS report #2211-000016-24, E-mail Correspondence between Complainant and Licensee, and interview with the DOC. [000856]

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program provided strategies to reduce or mitigate falls of a resident including the use of equipment, supplies, devices and assistive aids after they experienced a fall.

Rationale and Summary
A Critical Incident Systems report (CIS) indicated that a resident experienced a fall while ambulating to the washroom, resulting in injuries, and was transferred to hospital for further assessment. Upon return from hospital, the resident was re-assessed by the Kinesiologist (KIN) and was provided a device for ambulation.

At the time of inspection, the resident was at high-risk for falls and experienced a second fall. The resident sustained injuries. A post fall assessment was completed, and no new interventions were implemented.

The KIN indicated that new interventions should have been implemented and updated in the resident's plan of care after their second fall.

The Director of Care (DOC) admitted that the current care plan was ineffective in managing the resident's falls and that the care plan should have been updated with new interventions.

Failure to provide strategies to reduce or mitigate falls increased the risk of incidence of falls and the risk of injury.

Sources: Observations of the resident's room; the resident's electronic health records; CIS #2211-000017-24, interview with the KIN, the DOC and other relevant staff. [698]