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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# Public Report

**Report Issue Date:** March 7, 2025

**Inspection Number:** 2025-1058-0001

**Inspection Type:**
Complaint
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): February 26-28, 2025 and March 4-7, 2025

The following Complaint intake(s) were inspected:

- Intake: #00138840 - related to improper care/neglect, continence care, bowel management, pain management, oral care, plan of care, nutritional care and hydration program, skin and wound care, positioning

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

- Intake: #00136936 [CI #2211-000001-25] - related to improper care/medication administration
- Intake: #00137355 [CI #2211-000002-25] - related to a disease outbreak

The following intake(s) were completed:

- Intake: #00131858 [CI #2211-000026-24] - related to a disease outbreak

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident was given an opportunity to participate fully in the implementation of their plan of care related to medication administration. A resident expressed concerns about the medications a Registered Practical Nurse (RPN) administered to them and asked for another staff's assistance. The RPN did not understand the resident but insisted they take the medications. It was identified that the medications were not prescribed for the resident.

**Sources:** Review of the home's investigation notes, Interview with a resident and relevant staff.

## WRITTEN NOTIFICATION: ADMINSTRATION OF DRUGS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (1)**
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed

for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident. An RPN administered medications to a resident that were not ordered for that resident.

**Sources:** Review of the home's investigation notes, Interview with a resident and relevant staff.