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

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Public Report

Report Issue Date: May 20, 2025
Inspection Number: 2025-1058-0002
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): May 8-9, 12-16, and 20, 2025

The following intake(s) were inspected:

- Intake: #00143287, Critical Incident System (CIS) # 2211-000004-25, related to infection prevention and management
- Intake: #00144058, CIS # 2211-000008-25, related to loss of essential services

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (1) (c)
Accommodation services
s. 19 (1) Every licensee of a long-term care home shall ensure that,
(c) there is an organized program of maintenance services for the home.

The licensee has failed to ensure that there was an organized program of maintenance services for the home. Specifically, staff within the home did not track requests related to elevator systems malfunctions, service requests, and issue resolution within the home.

Sources: Interviews with the home's staff and review of elevator contractor service records.

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that all contact surfaces in residents' rooms were disinfected at least once daily using a low-level disinfectant.

In accordance with O. Reg. 246/22 s. 11(1) (b), the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces. Discrepant practices and knowledge of the correct product to use were noted over several days among housekeeping, supervisory, and infection prevention and control staff related to the correct product for disinfecting the washroom sink. Housekeeping staff stated that they used a toilet bowl cleaner product rather than disinfectant on washroom sinks.

Sources: Interviews with staff, observations of disinfection products and processes, and reviews of cleaning policy/procedure.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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).

The licensee failed to ensure that there are policies and procedures in place to determine the frequency of cleaning and disinfection using a risk stratification approach in accordance with Section 5.6 of the IPAC Standard for Long-Term Care Homes (September 2023). Specifically, the home's cleaning procedure did not incorporate a risk-based approach to surface cleaning frequencies.

Sources: Interviews with staff, record reviews, email correspondence with staff.

WRITTEN NOTIFICATION: Emergency plans

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (2)
Emergency plans
s. 268 (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are recorded in writing.

The licensee has failed to ensure that the long-term care home's emergency plans were recorded in writing for the loss of essential services. Specifically, there was no written emergency plan pertaining to elevator service failure. The home had only one elevator with a history of component failures that would result in the elevator being out of service until repairs could be made.

Sources: The home's staff and reviews of the documentation related to emergencies and elevator service disruptions.