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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: April 4, 2025
Inspection Number: 2025-1028-0002
Inspection Type: Complaint
Licensee: Maplewood Nursing Home Limited
Long Term Care Home and City: Maple Manor Nursing Home, Tillsonburg

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 24-27, 31, and April 1-4, 2025

The following intake was inspected:

- Intake: #00137795 - Complaint related to resident care and support services, medication management and falls prevention and management

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to implement the home's falls prevention and management program when a resident experienced a fall. Specifically, staff did not complete a head to toe assessment and post falls assessment when notified of the fall, or call the physician as was expected.

Sources: Resident's progress notes, Falls Prevention and Management Program policy and interview with the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the home's medication management system was

implemented when the staff member who discovered a medication incident for a resident, failed to complete a medication incident report as was required.

Sources: Resident's progress notes and Medication Administration Records (MAR), Medication Incident Policy Overview and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 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 a resident did not receive a medication that was not prescribed them. The resident was administered the medication in error after staff did not follow the steps as required when the medication was discontinued.

Sources: Resident's progress notes, orders, MAR, medication incident report, and interviews with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that the medication ordered for a resident was administered in accordance with the directions provided by the prescriber on two separate occasions.

First, staff failed to follow the steps required when the prescriber changed an order and as a result, the resident's medication was started on the incorrect date.

In addition, staff failed to manage the situation as was expected when they were unable to locate a medication for administration, which resulted in a missed dose of the resident's medication.

Sources: Resident's MARs, medication incident report and interview with the DOC.

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (c)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee failed to ensure that there was a written record of the analysis and corrective actions taken for a medication incident involving a resident.

In addition, the licensee failed to ensure that there was a written record of the corrective actions taken for a separate medication incident involving the same

resident.

Sources: Resident's progress notes, medication incident reports and interview with the DOC.