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
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: June 19, 2025
Inspection Number: 2025-1028-0005
Inspection Type: Critical Incident
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 date(s): May 29, 30, 2025 and June 2, 3, 4, 5, 6, 9, 10, 11, 12, and 19, 2025
The inspection occurred offsite on the following date(s): June 13, 2025
The following intake(s) were inspected:

- Intake: #00146983/Critical Incident System (CIS) report #1049-000019-25 related to a medication incident and adverse reaction;
- Intake: #00147338/CIS #1049-000020-25 related to a disease outbreak;
- Intake: #00147367/CIS #1049-000021-25 related to falls prevention and management;
- Intake: #00147552/CIS #1049-000022-25 related to improper care.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that the care plan and kardex for a resident were updated when the resident's care needs changed.

Failure to update the care plan and kardex to reflect this change, may have led to confusion about the resident's activity orders and increased the risk of further physical decline.

Sources: Review of the resident care plan and kardex; and interviews with Falls Lead #106 and Registered Nurse #107.

WRITTEN NOTIFICATION: Required Programs

NC #002 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 has failed to comply with the home's falls prevention and management program when the Power of Attorney (POA) was not notified of a fall for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written programs developed are complied with.

As per the home's "Falls Prevention and Management Program", registered staff were required to notify the POA of the fall, intervention, and status of the resident.

Multiple staff interviews confirmed that the resident's POA should have been notified. There were no records indicating that the POA was notified of the resident's fall.

Sources: Review of the home's "Falls Prevention and Management Program" policy dated February 1, 2024, the resident's progress notes; and interviews with staff members #105, #106, and #107.

WRITTEN NOTIFICATION: Designated Lead

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 70 (1)
Designated lead
s. 70 (1) Every licensee of a long-term care home shall ensure that the home's restorative care program, including the services of social workers and social service

workers, are co-ordinated by a designated lead. O. Reg. 246/22, s. 70 (1).

The licensee has failed to ensure there was a Restorative Care Lead to co-ordinate the restorative care approaches in the home.

A Restorative Care Lead is required to maintain or improve the functional and cognitive capacities for all residents, in all aspects of daily living, to optimize their abilities.

Staff interviews revealed there was no Restorative Care Lead at time of inspection. Upon request the home was unable to provide any policies or procedures to support they had a Restorative Care Lead.

Sources: Staff interviews with the Falls Lead, the Director of Care and the Administrator.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces,

The licensee has failed to ensure that as part of the organized program of

housekeeping, that procedures were implemented for cleaning of the home, including resident bedrooms that were under droplet and contact precautions.

The home's housekeeping "Standards of Practice" policy stated that before cleaning a resident room housekeepers were to gather materials required for cleaning prior entering the room.

A housekeeper was observed cleaning a resident room that was under additional precautions. The housekeeper failed to gather the materials required for cleaning prior entering the room.

Sources: IPAC observations in the home, review of the home's "Standards of Practice" policy #ICM-XII-010 dated June 17, 2024; and interviews with a Housekeeper, the Nutrition and Environmental Manager, and the IPAC Lead.

WRITTEN NOTIFICATION: Administration of Drugs

NC #005 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 has failed to ensure that a resident was administered their medication as ordered.

The registered nursing staff did not complete the correct rights of medication administration and administered a resident's medications to another resident,

therefore the resident did not receive their medications as ordered.

Sources: Review of Critical Incident System report #1049-000019-25, a resident's clinical record, a Medication Incident Report Event, the registered nursing staff member's Workplace Incident Statement; and interviews with the Director of Care.

COMPLIANCE ORDER CO #001 Plan of Care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Observe and evaluate a Personal Support Worker (PSW)'s process for providing specific care to two separate residents on one occasion each, based on their written plans of care.
2) A documented record must be maintained of these evaluation's, including the date the evaluation's were completed, the evaluator and any corrective actions taken.

Grounds

The licensee has failed to ensure that the care required in the plan of care for a resident was provided to the resident as specified in the plan.

A PSW did not provide care to a resident as per the resident's kardex which resulted in an injury to the resident.

Sources: Review of Critical Incident System (CIS) report #1049-000022-25, Workplace Incident Statement Form completed by the PSW, the plan of care for the resident, and interviews with PSW #106, PSW #111, and the Director of Care.

This order must be complied with by July 11, 2025

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Review the housekeeping shift routines and housekeeping schedule to ensure there is adequate housekeeping coverage on weekends and holidays to complete disinfection of high touch surface areas daily.
2) Review the housekeeping shift routines and housekeeping schedule to ensure there is adequate housekeeping coverage during outbreaks to complete disinfection of high touch surface areas twice daily.
3) Complete in person retraining with housekeepers regarding the process for

cleaning high touch surfaces.
4) Retrain two specific Personal Support Workers (PSWs) and a housekeeper on PPE requirements when cleaning or providing care to residents who are on additional precautions.
4) Maintain a record of the training provided, including the content, date, signature of attendants, and the name of staff member(s) who provided the education.
5) Complete environmental audits weekly to ensure all high touch surfaces are being cleaned and disinfected. Audits are to be completed until this order is complied.
6) Maintain a record of all audits, including the location of the audit, name of the housekeeper, name of the staff member who completed the audit and any action taken as a result of any deficiencies noted.

Grounds

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

A) Section 11.6 of the IPAC Standard for Long-Term Care Homes revised September 2023, states the licensee shall post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Observations of the home noted passive screening was not posted throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

B) Section 9.1 (f) of the IPAC Standard for Long-Term Care Homes revised September 2023, states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include additional PPE requirements including appropriate selection application, removal and disposal.

Two Personal Support Workers (PSWs) and a housekeeper were observed going into a resident's room which was under additional precautions, neither staff members were wearing appropriate PPE.

Sources: IPAC observations in the home, review of the resident's clinical record and interviews with the IPAC Lead, and other staff.

C) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Section 5.6 of the IPAC Standard for Long-Term Care Homes revised September 2023, states the licensee shall ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency; and that adequate personnel are available on each shift to complete required surface cleaning and disinfection.

Southwestern Public Health Confirmed Outbreak Control Measures for an outbreak at the home indicated that the environmental cleaning frequency should be a minimum twice daily for high touch surfaces (i.e. door handles, light switches, handrails, phones, etc.)

Housekeeping staff reported reduced weekend and holiday staffing, which lead to

high-touch surfaces being disinfected less than the required twice daily frequency, especially during the home's outbreak.

The Nutrition and Environmental Manager confirmed that housekeeping staff numbers decreased on weekends and holidays. During the recent outbreak, staffing was insufficient to ensure high-touch surfaces were disinfected twice daily.

The IPAC Lead reported that four environmental cleaning audits conducted over the past month revealed that high-touch surfaces were not being cleaned.

Reducing the number of housekeeping staff on weekends placed residents at risk, as high-touch surfaces were not cleaned at the required frequencies as required by the home's policies and procedures and SWPHU's Outbreak Control Measures.

Sources: IPAC observations in the home; Critical Incident System report #1049-000020-25, Southwest Public Health Confirmed Outbreak Control Measures, Outbreak Management Meeting minutes, the home's housekeeping "Standards of Practice" policy #ICM-XII-010 dated June 17, 2024, the home's "Department Responsibilities During Outbreak" policy ICM-IX-05 dated April 2025, High Touch Cleaning Record for Pandemic/Outbreak for May 12-26, 2025, the Housekeeping Schedule, the Housekeeping Shift Routine, Environmental Cleaning Audits; and interviews with housekeeping staff, the Nutrition and Environmental Manager, the IPAC Lead and the Administrator.

This order must be complied with by July 31, 2025

COMPLIANCE ORDER CO #003 Infection Prevention and Control Program

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide retraining to registered nursing staff on the home's outbreak management protocols related to reporting requirements to Southwest Public Health.
2) Maintain a record of the training provided, including the content, date, signature of attendants, and the name of staff member(s) who provided the education.

Grounds

The licensee has failed to ensure their outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act was complied with.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to

ensure that written policies developed for the infection prevention and control program were complied with. Specifically, the home's "Infection Monitoring" policy stated to notify public health if two or more residents with similar symptoms was detected.

A resident developed symptoms of infection, two days later another two residents developed similar symptoms of infection, and the next day an additional two residents developed symptoms of infection. It was not until the day after the last two residents developed symptoms, when the IPAC Lead was present, that the public health unit was contacted and the home was declared in outbreak.

Not following the home's reporting guidelines caused a delay in testing residents who were experiencing respiratory symptoms, and delayed implementation of outbreak measures. The outbreak affected seven residents.

Sources: Review of Critical Incident System report #1049-000020-25, the home's Outbreak Line Listing, the Outbreak Management Team meeting minutes dated May 30, 2025, The home's "Infection Monitoring" policy reviewed October 4, 2024, Southwest Public Health Unit's Management of Residents with Respiratory Symptoms; and interviews with Southwest Public Health Unit Public Health Inspector #118, the IPAC Lead and other staff.

This order must be complied with by July 25, 2025

COMPLIANCE ORDER CO #004 Administration of Drugs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:
1) The Director of Care (DOC) will develop and implement a plan to ensure a registered nursing staff member completes the correct rights of medication administration for residents.
2) The plan will be documented including any revisions made to the plan and any corrective action taken as a result of the plan.

Grounds

The licensee has failed to ensure that no drugs were administered to a resident unless the drug had been prescribed for the resident.

A registered nursing staff member failed to complete the correct rights of medication administration and administered a resident's medication to another resident. Later that day, the resident that received the wrong medication required medical intervention.

The resident suffered a change in health status requiring medical intervention when the registered nursing staff member failed to ensure they were administering medication to the correct resident.

Sources: Review of Critical Incident System report #1049-000019-25, the resident's clinical record, the Medication Incident Report, Workplace Incident Statements, the

home's investigation notes; and interviews with RN #103, Personal Support Worker #104 and the Director of Care. **This order must be complied with by** July 4, 2025

COMPLIANCE ORDER CO #005 Infection Prevention and Control Program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide retraining to registered nursing staff on the home's outbreak management protocols related to isolating and monitoring residents experiencing symptoms of infection.
2) Maintain a record of the training provided, including the content, date, signature of attendants, and the name of staff member(s) who provided the education.

Grounds

The licensee has failed to ensure that immediate action was taken to reduce transmission and isolate residents when two residents developed symptoms indicating the presence of infection.

A) A resident was not put into isolation until two days after they developed symptoms indicating the presence of infection. There was no documentation of the monitoring of the resident's symptoms on three specific shifts.

B) Another resident developed symptoms indicating the presence of infection. They were not put into isolation until the day after they developed symptoms. There was no documentation of the monitoring of the resident's symptoms on two shifts.

Both residents developed symptoms and were not put into isolation until the Infection Prevention and Control (IPAC) Lead was present. Failing to put the residents and their roommates in isolation posed a high risk of other residents developing respiratory symptoms.

Sources: Review of Critical Incident System report #1049-000020-25, the home's Outbreak Line Listing, the Outbreak Management Team meeting minutes dated May 30, 2025, the home's "Infection Monitoring" policy reviewed October 4, 2024, the residents' clinical records; and interviews with Southwest Public Health Unit Public Health Inspector #118, the IPAC Lead and other staff.

This order must be complied with by July 25, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.