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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: June 10, 2024	
Inspection Number: 2024-1570-0003	
Inspection Type: Critical Incident	
Licensee: United Counties of Leeds and Grenville	
Long Term Care Home and City: Maple View Lodge, Athens	
Lead Inspector Darlene Murphy (103)	Inspector Digital Signature
Additional Inspector(s) Erica McFadyen (740804)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4-7 and 10, 2024

The following intake(s) were inspected:

- Intake: #00112021/ CIS #M554-000004-24 - Fall of a resident resulting in injury
- Intake: #00114912/ CIS# M554-000007-24- Alleged staff to resident verbal abuse
- Intake: #00115224/ CIS#M554-000009-24 - Alleged improper/incompetent treatment of resident by staff
- Intake: #00116682/ CIS #M554-000010-24 -Alleged staff to resident emotional abuse

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the chair alarm in the falls plan of care for a resident was provided as specified in the plan on two specified dates during the inspection.

Sources:
Observations of the resident, interviews with the ADOC and a PSW, review of the plan of care for the resident
[740804]

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that a resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

Sources
Interview with the DOC, progress notes and care plan for the resident [740804]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee has failed to update the Director on the outcome of the staff member who was involved in an incident which required a report to the Director following the alleged abuse of a resident on a specified date.

The licensee has failed to update the Director on the outcome of the staff member who was involved in an incident which required a report to the Director following the alleged abuse of resident a resident on a different specified date.

Sources
Interview with the DOC, review of CIS #M554-000007-24 and CIS #M554-000010-24

[740804]