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
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 9, 2024
Inspection Number: 2024-1497-0003
Inspection Type: Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

Lead Inspector	**Inspector Digital Signature**
Shevon Thompson (000731)	Shevon M Thompson Digitally signed by Shevon M Thompson Date: 2024.05.23 13:15:12 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2, 3, and 6, 2024.

The following intake was inspected:

- Intake: #00113627 - CIR #3000-000020-24 - Complaint to the home regarding palliative care.

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

Infection Prevention and Control
Reporting and Complaints
Palliative Care

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; or

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed, the resident was assessed and palliative care was initiated.

Rationale and Summary:
During a review of a resident's plan of care the inspector noted the following; interventions on medication administration, Activities of Daily Living (ADLs) for bathing, dressing and eating and an intervention in the focus risk for falls, for the resident to use their mobility aid, were last reviewed in 2022, interventions on bed mobility and behaviour problems were last reviewed in 2023.

In an interview with the Director of Care (DOC) they confirmed that it was the home's expectation that the plan of care for the resident would have been reviewed and

updated when the resident's condition changed and would include updating the interventions for medication administration, ADLs, behaviours and falls. The DOC verified that If the resident was not taking oral medications and a device had been used for the administration of medication then the plan of care should have been updated to include it. After a review of the resident's plan of care, the DOC confirmed that the interventions for medication administration, ADLs, behaviours and falls in the plan of care should have been updated when the resident's condition changed.

Failure to ensure that the plan of care for the resident was reviewed and revised when the resident's care needs changed placed the resident at risk for not having their palliative care needs met.

Source: resident's electronic health record, Interview with DOC #103. [000731]

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 5.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
5. Palliative care.

The licensee has failed to ensure that the staff that provided direct care to a resident, as a condition of continuing to have contact with residents, received training in Palliative care.
In accordance with FLTCA 82 (7) 5. 7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Palliative care.
Per, O. Reg. 246/22 s. 261 (2) 1. The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

Rationale and Summary:
In a review of the staff's Education Status Report for 2023, the inspector noted the staff had not completed the palliative education course for Resident Care -End of Life titled Teepa Snow End of Life Care & Letting Go Part 1.

In an interview with the DOC, they confirmed that, based on the education record for the staff, the staff had not received palliative care training/education during the past year.

Failure to ensure that the staff received palliative education/ training placed the residents, receiving care from the staff, at an increased risk for improper/inadequate care due to lack of palliative knowledge by the staff.

Source: staff Education Status Report 2023 for the staff, Interview with the DOC, [000731].

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