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: June 21, 2024	
Inspection Number: 2024-1497-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Maxville Manor	
Long Term Care Home and City: Maxville Manor, Maxville	
Lead Inspector Dee Colborne (000721)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 18, 19, 20, 21, 2024.

The following intake(s) were inspected:

- Intake: #00116077 - Complaint to home about evening nourishment and snacks.
- Intake: #00116089 - Complaint with concerns regarding a medication pass.
- Intake: #00117311 -Complaint with concerns regarding harassment towards a resident.
- Intake: #00117538 - Verbal abuse allegations of a resident.
- Intake: #00117599 - Complaint with concerns regarding an upcoming discharge.
- Intake: #00118576 - Written complaint to home about sexual abuse.

- Intake: #00118596 - Complaint regarding interfering with family council.

The following Inspection Protocols were used during this inspection:

Residents' and Family Councils
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Reporting and Complaints
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident has the right to dignity and privacy during care, in that a third staff member was assigned to stand by.

Sources: Resident written plan of care, homes emails, interview with a PSW, RPN,

DOC, CEO and other staff.
[000721]

WRITTEN NOTIFICATION: Reporting of Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

The licensee has failed to ensure that an alleged incident of abuse towards a resident was immediately investigated.

Sources: Critical Incident (CI) report, Homes notes to legal counsel, interview with a resident, the CEO and DOC.
[000721]

WRITTEN NOTIFICATION: Family Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (6) 4.
Family Council
s. 65 (6) The following persons may not be members of the Family Council:
4. The Administrator.

The licensee has failed to ensure they are not a member in any capacity of family

council by appointing themselves as the family council assistant.

Sources: Email exchange with CEO and Family Council Chair, interview with the CEO.
[000721]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

1) The licensee has failed to ensure that the Ministry's toll free number for making complaints and its hours of service and contact for the patient ombudsman was included in the response letter to resident #001 in regards to the licensee's nourishment pass.

Sources: Critical Incident, Homes response letter and interview with DOC.
[000721]

1) The licensee has failed to ensure that the Ministry's toll free number for making complaints and its hours of service and contact for the patient ombudsman was included in the response letter to a resident in regards to a medication pass.

Sources: Critical Incident, Homes response letter and interview with DOC.
[000721

WRITTEN NOTIFICATION: Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3. iii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that a complaint response included advising the complainant that the complaint was forwarded to the Director as required by the Act.

Sources: Critical Incident, Emails, and interview with the DOC.
[000721]