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
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Original Public Report
Report Issue Date: November 21, 2024
Inspection Number: 2024-1497-0008
Inspection Type: Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13, 14, 18, 19, and 20, 2024

The following intake(s) were inspected:

- Intake: #00127272 - The fall of a resident resulting in an injury.
- Intake: #00127410 - The fall of a resident resulting in a significant change in the resident's condition.
- Intake: #00130445 - Physical abuse to a resident by another resident.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
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 care set out in the plan of care for a resident, not to have a specific device used for them, was provided to the resident as specified in the plan. On a specific date, the inspector observed the resident with the specified device being used for them. The expectation, that the device was not to be used for the resident, was confirmed by the Director of Care.

Sources: inspector's observation, resident's electronic health record, interviews with staff members and Director of Care.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for

falls. O. Reg. 246 / 22, s. 54 (2); O. Reg. 66 / 23, s. 11.

The licensee has failed to ensure that when a resident had fallen, on two specific dates in 2024, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. In a review of the resident's health record there was no post fall assessment completed for the falls on those specific dates, using a clinically appropriate assessment instrument that was specifically designed for falls. The Director of Care confirmed that it is the expectation that a post fall assessment was to be completed after every fall.

Sources: resident's electronic health record and interview with the Director of Care.