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

Public Report

Report Issue Date: March 6, 2025

Inspection Number: 2025-1497-0001

Inspection Type:
Complaint
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): February 18, 19, 20, 24, 25, 26, 27, 2025 and March 3, 2025

The following intake(s) were inspected:

Intake: #00134792 - CI: 3000-000074-24 - related to environmental hazard resulting in flooding in residents' care area.
Intake: #00134935 – CI:3000-000077-24 – related to Infection Prevention and Control (IPAC)
Intake: #00138272 – CI: 3000-000003-25- fall of a resident resulting in injuries.
Intake: #00138462 – complaint related to the care of a resident.
Intake: #00139074 - complaint with concerns regarding resident care and services.
Intake: #00139317 – complaint related to resident care and services.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of Substitute Decision Maker with Resident Plan of Care.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was given the opportunity to participate fully in the implementation of an identified resident's plan of care.
Specifically on three days in the month of January 2025, when the identified resident experienced a significant change in health status. The substitute decision maker (SDM), was not made aware until the resident was later diagnosed with an illness on a specific day in January 2025.

Sources: resident's health care record and interviews with staff.

WRITTEN NOTIFICATION: Chemicals not secured or labelled on housekeeping carts

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances

s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that a hazardous substance specifically, a cleaning product was kept inaccessible to residents at all times, and labelled properly.
On a day in February 2025, observations were made in the home on all resident units and noted that all housekeeping carts did not have locked storage for chemicals.

Sources: observations made on resident home units, record review, and interviews with staff.