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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Public Report

Report Issue Date: April 3, 2025

Inspection Number: 2025-1497-0002

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): March 24, 25, 26, 27, 28, 2025 and April 1, 2, 2025

The following intake(s) were inspected:

- Intake: #00140208 and #00142685 - related to falls prevention and management; and,
- Intake: #00141506 - related to an incident of alleged staff-resident abuse.

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

Medication Management
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 a resident's plan of care was provided to the resident as specified in the plan, related to falls prevention.

In the description of a fall incident, it was indicated that a specified device being used for the purpose of falls prevention had not been set-up for the resident as would be required for it's purpose.

During the inspection, the inspector observed a resident to be in their room, unattended. An intervention that was included in the resident's plan of care for the purpose of falls prevention, was not in place at the time.

Sources: observations of the inspector, a review of resident health care records, including care plan and relevant risk management/incident notes; and, staff interviews, including interviews with a PSW and RPN.

WRITTEN NOTIFICATION: Security of drug supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2.
Security of drug supply

s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
2. Access to these areas shall be restricted to,
i. persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.

The licensee has failed to ensure that access to areas where drugs are stored was restricted to persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and the Administrator.

During the inspection, the inspector observed two non-nursing staff members to each, separately, access a locked medication room using a key, where medications were accessible.

Sources: observations of the inspector and staff interviews, including interviews with an RPN and the Director of Care (DOC).