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

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Original Public Report

Report Issue Date: August 21, 2024
Inspection Number: 2024-1259-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: Maplewood Nursing Home Limited
Long Term Care Home and City: Cedarwood Village, Simcoe

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 12, 13, 14, 15, 16, 19, 2024

The following intake(s) were inspected:

- Intake: #00119306 - Critical Incident System (CIS) #2768-000016-24 - alleged neglect of multiple residents
- Intake: #00121365 - CIS #2768-000018-24 - alleged neglect of a resident and complaint response
- Intake: #00121841 - anonymous complaint concerning alleged physical abuse and neglect of residents
- Intake: #00121618 - complaint concerning hot temperatures in the home and alleged neglect of a resident
- Intake: #00121659 was a Follow-up regarding Compliance Order (CO) #007/Inspection 2024-1259-0002 related to altercations between residents
- Intake: #00121660 was a Follow-up regarding CO #002/Inspection 2024-

1259-0002 related to resident-to-resident physical abuse
- Intake: #00121662 was a Follow-up regarding CO #005/Inspection 2024-1259-0002 related to air temperatures in the home
- Intake: #00121663 was a Follow-up regarding CO #003/Inspection 2024-1259-0002 related to cooling requirements in the home
- Intake: #00121664 was a Follow-up regarding CO #001/Inspection 2024-1259-0002 related to air conditioning requirements
- Intake: #00121665 was a Follow-up regarding CO #004/Inspection 2024-1259-0002 related to measurement of air temperatures in the home

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #007 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 59 (b)

Order #002 from Inspection #2024-1259-0002 related to FLTCA, 2021, s. 24 (1)

Order #005 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 24 (3)

Order #003 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 23 (4)

Order #001 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 23.1 (3) 1.

Order #004 from Inspection #2024-1259-0002 related to O. Reg. 246/22, s. 24 (2) 1.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

The licensee has failed to ensure that residents who required assistance with a care need received assistance with continence care.

Rationale and Summary:
A Critical Incident System (CIS) Report was received by the Director concerning a number of residents who experienced an incident with their continence care.

Two residents were identified in the CIS report and in the home's internal investigation notes as being affected by the incident. During a record review, the resident's care plans informed that both residents required assistance with a care need and required continence care.

A Personal Support Worker (PSW) work document for a particular shift identified that care rounds were expected to be completed at specific times.

A PSW advised in an interview that a resident was discovered at the beginning of their shift and the resident's continence product had not been changed and the resident was not dry.

In an interview with the Director of Care (DOC) they advised that through their internal investigation and review of the video footage of the unit, they determined that care rounds were not completed as expected.

There was a risk to two resident's skin integrity when they were not assisted with a particular care need.

Sources: Staff interview, CIS report, internal investigation notes, two resident's care plans, PSW work document.