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: March 18, 2024	
Inspection Number: 2024-1570-0002	
Inspection Type: Critical Incident	
Licensee: United Counties of Leeds and Grenville	
Long Term Care Home and City: Maple View Lodge, Athens	
Lead Inspector Cheryl Leach (719340)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13, 14, 2024

The following intake(s) were inspected:

- Intake #00102382-CIR M554-000022-23-Alleged staff to resident neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and Response System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that a resident had access to the communication and response system (call bell) when they were left unattended during toileting.

Rationale and Summary:

Progress note from November 2023 indicated that a resident was left on the toilet unattended for one hour and their call bell was not within reach.

The resident's care plan indicated they required one to two person extensive assistance for toileting and the call bell was to be within reach for safety.

During an interview, Personal Support Worker (PSW) #102 stated that on a specified date in November 2023, a resident was left on the toilet unattended for 30 to 40 minutes and the call bell was not within reach.

During an interview, Director of Care (DOC) #101 stated that on a specified date in November 2023, a resident was left on the toilet unattended for approximately 30 minutes and the call bell was not within reach.

Resident required extensive assistance with toileting and was left on the toilet unattended for 30 to 60 minutes without access to the call bell which caused an increased risk for injury.

Sources: Resident's care plan and progress notes and interviews with PSW #102 and DOC #101.

[719340]