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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 21, 2024
Inspection Number: 2024-1047-0001
Inspection Type: Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: The Maples Home for Seniors, Tavistock

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.05.21 13:32:32 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 2024

The following intake(s) were inspected:

- Intake: #00109252, related to a resident's fall.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 was provided to the resident as specified in the plan.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report related to a resident fall.

A clinical record review for the resident and an interview with the Director of Care (DOC) showed a specific fall prevention intervention for the resident was not provided by a specific Personal Support Worker. The DOC said the expectation was for the staff to provide care to the resident as specified in their plan of care.

The resident was put at risk when staff did not provide care to the resident as specified in their plan of care.

Sources: staff interviews, clinical records. [523]