Original Public Report

Report Issue Date September 26, 2022
Inspection Number 2022_1395_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063415 Ontario Limited as General Partner of 2063415 Investment LP

Long-Term Care Home and City
Maple Grove Care Community, Brampton

Lead Inspector **Inspector Digital Signature**
Janet Groux #606

Additional Inspector(s)
Deborah Nazareth #741745

The inspection occurred on the following date(s): August 15-19, 24-26, 2022.

The following intake(s) were inspected:

- Intake #013017-22, and intake #008448-22, related to the home's falls prevention and management program,
- Intake #004261-22, related to an allegation of abuse, and
- Intake #012567-22, related to the home's pain management program.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE: CRITICAL INCIDENTS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115(5)(4)

The licensee has failed to ensure a Critical Incident System (CIS) report was amended within ten days to include the outcome status of a resident.

Rationale and Summary:

A CIS report stated that a resident was transferred to the hospital and diagnosed with a significant change in status. The CIS report was not updated to include the outcome status of the resident within ten days. The ADOC acknowledged this.

Sources:

A CIS report and interview with the ADOC. [606]

WRITTEN NOTIFICATION: NOTIFICATION RE: INCIDENTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 104(2)(ii)

The licensee failed to ensure that, when making a report to the Director, the names of any staff members or other persons who were present at or discovered the incident was included in the report.

Rationale and Summary:

A CIS report reported an allegation of staff to resident abuse.

The home's investigation records identified an RPN as the staff involved in the incident with the resident. The ADOC acknowledged the CIS was not amended to include the RPN's name as required.

Sources:

A CIS report, the home's investigation records for the CIS, and interviews with staff and the ADOC. [606]

WRITTEN NOTIFICATION: RESIDENTS BILL OF RIGHTS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 3(1)(1)

The licensee has failed to ensure a resident was treated with courtesy and respect.

Rationale and Summary:

A CIS report detailed an allegation of abuse.

A resident alleged that a staff member approached them inappropriately. They were very upset and did not sleep well.

The RPN acknowledged that they should not have approached the resident in that specific manner and should have asked another staff for assistance.

Failure for the RPN to approach the resident in a manner that was appropriate for the resident caused the resident to become upset and uncomfortable and contributed to the resident's sleep disturbance that night.

Sources:

A CIS, the home's investigation records, a resident's progress notes, and interviews with staff. [606]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 102 (2)(b)*

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed.

Rationale and Summary:

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC. The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (LTCH), April 2022, provided additional requirements for IPAC programs in long-term care homes.

A) The IPAC Standard for LTCHs, dated April 2022, section 9.1 e) for Additional Precautions states that at a minimum, there should be point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident was on isolation but there was no point-of-care signage indicating that enhanced IPAC control measures were in place. A staff went into the room and was not aware that the

resident was on isolation. The IPAC lead stated that residents on isolation may be moved from their room to another location and all signage should go with them.

B) The IPAC Standard for LTCHs, dated April 2022, section 4.1 i) stated that the outbreak management system shall include strategies to address various modes of disease transmission in outbreaks. The home's policy on Personal Protective Equipment, stated all Team Members will use professional judgement and guidelines in making a decision about the type of barrier equipment to be used considering: The type of situation and nature of intervention. The home was instructed by Peel Public Health to wear N95 masks and eye protection on the affected outbreak units.

A notice on the door to an outbreak unit, stated, "PLEASE WEAR N-95 MASK AND EYE PROTECTION BEFORE ENTERING THIS UNIT". An RN was observed on the outbreak unit, wearing an N95 mask, however eye protection was tucked into the front of their shirt. The RN was interacting with residents while not wearing eye protection. The RN acknowledged they were not wearing their eye protection when they should have been.

C) The IPAC Standard for LTCHs, dated April 2022, section 9.1 b) for Routine Practices states at a minimum the IPAC program should include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

The home's Hand Hygiene policy, stated all team members and volunteers will practice hand hygiene to reduce the spread of infection. All Team Members/Volunteers/Visitors will practice hand hygiene according to the 4 moments of hand hygiene; Before initial resident environment contact; Before aseptic procedure; After body fluid exposure risk; After resident environment contact. The policy also states that alcohol-based hand rub (ABHR) is to be used before entering a resident's room and before exiting a resident's room.

An RN entered a resident's room to take their temperature. Hand hygiene was not performed before entering or after leaving the resident's environment. The RN then proceeded to take the temporal temperatures of residents seated in the dining room. Hand hygiene was not observed upon entering the dining room or between taking resident temperatures. The IPAC lead stated that staff are to perform hand hygiene before and after going into residents rooms.

As a result of the staff not adhering to the home's PPE and hand hygiene requirements and lack of point-of-care signage indicating that enhanced IPAC control measures were in place, there was risk of harm to residents and staff from possible transmission of infectious agents which included COVID-19.

Sources: Observations, Interviews with staff and the IPAC Lead, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), Home's policies, Hand Hygiene and Personal Protective Equipment. [741745] [606]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

WRITTEN NOTIFICATION CMOH AND MOH

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184(3)

The licensee has failed to comply with the Minister's Directive: Covid-19 response measures for long-term care (LTC) homes, effective April 27, 2022, when they used expired ABHR and masks in the home.

In accordance with the Minister's Directive: Covid-19 response measures for LTC, the licensee was required to follow the Ministry of Health (MOH) COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units Version 7, dated June 27, 2022, for additional outbreak measures.

Rationale and Summary:

(A)The MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units document referenced the PHO fact sheet, Selection and Placement of ABHR during COVID-19 in LTC and Retirement Homes, November 6, 2020, which states not to use expired product [ABHR] and to note product expiration date when selecting product.

Expired hand sanitizers were observed in the following areas of the home; on a table with PPE outside of a home area that was on outbreak, in the elevator, outside of three resident rooms, who were on additional precautions, in the activity room on a home area and in the lobby. Observed expiry dates included 02/06/2022, 06/2022, and 07/2022.

(B)The MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units document also referenced the COVID-19 Guidance: PPE for Health Care Workers and Health Care Entities, version 1.0, June 10, 2022, which stated that health care entities are accountable for assessing the available supply of PPE on an ongoing basis and the supply should be monitored frequently to identify product expiry.

Expired medical face masks were observed on a table with PPE before entering the Lake House home area, at the Lake House nursing station and in the lobby. Expiry date was 20220525.

A staff stated they were instructed by management that expired products can be used up to 6 months after the expiry date. The IPAC lead checked with the manufacturer and Public Health and there was no direction to use these products past the posted expiry date.

As a result of the facility using expired hand sanitizers and medical masks there was risk of harm to residents and staff from possible transmission of infectious agents which included COVID-19.

Sources: Observations, interviews with staff and the IPAC Lead. COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, Version 1.0 June 10, 2022, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes, November 6, 2020. [741745] [606]

COMPLIANCE ORDER [CO#001] PLANS OF CARE

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6(10)(c) and LTCHA, 2007 s. 6(10)(c)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6(10)(c) of FLTCA, 2021 and s. 6(10)(c) of LTCHA, 2007.

The licensee shall:

1. Re-educate registered staff on the process for investigation of a fall incident. This includes reviewing the falls interventions in the care plan and completing all sections of risk management including but not limited to, the predisposing factors and situations that may have contributed to the fall.
2. Develop, implement and document a process to ensure the physiotherapist's post-fall assessments and recommendations for falls prevention are included in the residents care plan.
3. Develop and conduct an audit for a two week period to ensure the following is completed for each fall:
   a) Risk management post fall analysis
   b) Review and revision, where appropriate, of falls interventions in the he care plan
   c) Physiotherapy recommendations are reviewed and included in the falls prevention and management program.

Grounds

Non-compliance with: FLTCA, 2021 s. 6(10)(c) and LTCHA 2007, s. 6(10)(c)

The licensee has failed to ensure a resident's plan of care was reviewed and revised to include different approaches to address the resident's fall risks when current interventions were not effective.

Rationale and Summary:

A Critical Incident System (CIS) report stated a resident fell and was transferred to the hospital with a significant change in their status.

The resident was assessed at high risk level for falls, and the resident's falls prevention care plan, stated the resident was to have specific interventions in place for falls prevention and management.

The resident's risk management reports identified that the resident had a number falls where the resident had been found on the floor beside their bed or on the bathroom floor.
The resident fell again and was transferred to the hospital and admitted and diagnosed with a significant change in their status.

The resident returned to the home and continued to have falls. The resident's falls care plan was not updated with different approaches for falls prevention and management.

The physiotherapist completed assessments upon admission and after each time they fell. They made recommendations for falls prevention and management for the resident. The plan of care for falls was not revised with these interventions until after the resident fell eight times.

The ADOC acknowledged that the resident's falls prevention and management care plan was not updated when the interventions to prevent and manage their falls were not effective.

Failure to revise the resident's care plan to include different approaches to manage the resident's fall risks may have contributed to the resident's fall and subsequent injury.

Sources:
A CIS, the home's Falls Prevention and Management policy, a resident's progress notes, risk management reports, care plan and interviews with staff. [606]

This order must be complied with by October 17, 2022.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.