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

Central West District
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Original Public Report

Report Issue Date: December 30, 2022	
Inspection Number: 2022_1395_0002	
Inspection Type: Complaint Follow up (FU)	
Licensee: 2063415 Ontario Limited as General Partner of 2063415 Investment LP	
Long Term Care Home and City: Maple Grove Care Community, Brampton	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.01.06 13:24:58 -05'00'
Additional Inspector(s) Mark Molina (#000684) was also present for this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 14-15, 19-22, 2022

The following intake(s) were inspected:

- Intake #00013894, FU Inspection #2022_1395_0001, Order #001 related to FLTCA, 2021 s. 6(10)(c) and LTCHA, 2007, s. 6(10)(c). Compliance Due Date: October 17, 2022.
- Intake: #00013980 - complaint related to care concerns.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
FLTCA, 2021 and LTCHA, 2007	s. 6(10)(c)	2022_1395_0001	#001	Katherine Adamski (#753)

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

Infection Prevention and Control
Falls Prevention and Management
Medication Management
Skin and Wound Prevention and Management
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that any written complaints that it had received concerning the care of a resident were not immediately forwarded to the Director, where the complaint had been submitted in the format provided for in the regulation and complied with any other requirement that may be provided for in the regulations.

Rationale and Summary
The home's management team received multiple emails from a resident's Power of Attorney (POA). The emails included concerns about the resident's safety and alleged harm related to care being provided to the resident by the home.

The Director of Care (DOC) acknowledged that the home had investigated each complaint received from the resident's POA. The DOC believed that the initial complaint had been reported to the Director, however they were not able to substantiate this.

A review of the Ministry of Long-Term Care (MLTC) reporting portal showed there were no Critical Incidents (CI) or complaints related to the resident forwarded to the Director.

As a result of not immediately forwarding the written complaints to the Director, the Director could not respond to the complaints, if required.

Sources: Emails, Written Response Letter, Complaint Record, interviews with the resident's POA, the home's DOC and other staff, MLTC reporting portal. [#753]