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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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: July 11, 2023

Inspection Number: 2023-1395-0003

Inspection Type:
Critical Incident System

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**
Daniela Lupu (758)	Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.07.26 15:45:48 -04'00'

Additional Inspector(s)
Romela Villaspir (653)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 15-16, 20-23, and 26-29, 2023
The inspection occurred offsite on the following date(s): June 19, 2023

The following intake(s) were inspected:

- Intake #00005016, related to a choking incident of a resident
- Intake #00009133, related to falls prevention and management
- Intake #00014287, #00084232, and #00090643, related to improper care
- Intake: #00020012, and #00084055, related to abuse.

The following intake(s) were reviewed during this inspection:

- Intake #00084721, #00015290, #00017905, and intake #00087215, related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 108 (2)

The license failed to ensure that a record of a complaint related to allegations of abuse of a resident was kept in the home.

Rationale and Summary

The home's Director of Care (DOC) received a complaint alleging abuse of a resident by an unknown staff member.

The DOC said that a documented record was not completed for this complaint, as required.

Sources: a critical incident report, a resident's clinical records, the home's investigation records, and an interview with the DOC. [758]

Date Remedy Implemented: June 28, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect, was

fully respected and promoted.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) related to an incident involving a resident and a Personal Support Worker (PSW).

During the provision of care, a PSW had an inappropriate interaction with a resident. The resident was upset and asked the DOC not to have that specific PSW providing care to them.

This has not been maintained, and for approximately four months after the incident, the same PSW continued to provide care to the resident.

The resident's right to be treated with courtesy and respect was not fully respected and promoted when the PSW's actions and remarks towards the resident were inappropriate, and the home did not accommodate the resident's request in a timely manner, not to have the same PSW provide care to them following the incident.

Sources: a resident's clinical health records, a critical incident report, the home's investigation notes, and interviews with a resident, a PSW, the DOC and other staff . [653]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care related to falls prevention was provided to the resident as specified in the plan.

Rationale and Summary

A resident was at risk for falls and their plan of care documented specific falls prevention interventions to be in place.

The resident had a fall and sustained an injury, and one of their falls prevention interventions was not provided as required.

Observations made during this inspection showed that two falls prevention interventions were not provided as specified in the resident's plan of care.

The DOC said staff should have followed the falls prevention interventions as indicated in the resident's plan of care.

By not ensuring that the resident's falls prevention interventions were provided as per their plan of care, increased the resident's risk of falling as staff may not intervene in a timely manner to mitigate the risk for falls.

Sources: observations of a resident's falls prevention interventions, a resident's clinical records, a critical incident report, and interviews with two PSWs, an RPN, the Physiotherapist, and the DOC. [758]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for two residents.

Rationale and Summary

The home's written policy to promote zero tolerance of abuse and neglect of residents documented that in the event of a witnessed or suspected incident of resident abuse, the nurse would check the resident's condition to assess their safety, emotional and physical wellbeing, and follow the steps outlined in the Checklist for Investigating Alleged Abuse. The Checklist directed staff immediately upon becoming aware of an incident of resident abuse, to document subjective comments made by the resident and objective observations of the resident and to complete minimum documentation and assessment of the resident's status each shift within 24 hours.

The Executive Director or designate, upon first receiving notification by the team member, would immediately determine whether or not the team member should be sent home immediately. If so, the team member must be told that they were being sent home with pay, pending investigation of the incident. The Executive Director or designate would interview the resident, other residents, and/or persons who may have knowledge of the situation. If possible, a witness that should be management from the community was to be included during interviews with all residents to take detailed notes of the conversation.

A. The home submitted a CI report to the MLTC related to an allegation of staff to resident physical and emotional abuse.

A resident informed RN of an incident of alleged abuse.

The RN did not follow the home's policy in relation to assessing and documenting the incident when they suspected abuse.

The PSW was not immediately placed on administrative leave pending the outcome of the investigation. Additionally, the resident was not interviewed by the two ADOCs who initiated the investigation.

By not following the home's policy, the risk to the resident was not mitigated as the PSW continued to work in the facility until two days after the incident. Furthermore, the impact to the resident may not have been identified.

Sources: a resident's clinical health records, a critical incident report, the home's investigation notes, the home's Prevention of Abuse and Neglect of a Resident policy, Prevention of Abuse - Checklist for Investigating Alleged Abuse policy, a PSW's attendance records and interviews with a resident, a PSW, RPNs, RNs, BSO RPN, ADOC, RFEC, and the DOC. [653]

B. The DOC received a complaint alleging physical abuse of a resident by an unknown staff member and a critical incident was submitted to the Director.

An RN said they spoke with the resident, but did not follow their policy in regards to assessing and documenting the follow up after the incident.

The DOC said that staff were expected to follow the steps outlined in the home's check list for investigating the resident's alleged abuse.

As a result of not following the home's policy, there was a risk that any potential injuries may not have been identified and that essential information related to the incident may have been missed.

Sources: a critical incident report, a resident's clinical records, the home's Prevention of Abuse and Neglect of a Resident, Prevention of Abuse - Checklist for Investigating Alleged Abuse policy, the home's investigation notes, and interviews with an RPN, an RN and the DOC. [758]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 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 complaint that it had received concerning the care of a

resident were immediately forwarded to the Director, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary

A resident had an incident and was transferred to the hospital for further assessment. On the same day, the former Executive Director (ED) received two written communications expressing concerns and requesting for a full report on the resident's incident.

Three days later, the former Associate Director of Care (ADOC) received a written communication outlining detailed concerns related to the incident.

The home did not immediately forward the written complaint to the Director.

By not immediately forwarding the written complaint to the Director, it may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: a resident's clinical records, written complaints and responses, a critical incident report and an interview with the Director of Care (DOC). [653**]**

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

The home submitted a CI report to the MLTC related to an allegation of a resident's abuse.

An RN suspected staff to resident abuse and immediately reported it to the Resident and Family Experience Coordinator (RFEC), who interviewed the resident on the same day, and reported the incident to the ADOC.

The incident was not reported to the Director until one day later.

The home's failure to immediately report the allegation of abuse to the Director, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: a resident's clinical health records, a critical incident report, the home's investigation notes, and interviews with a resident, an RN, an ADOC, the DOC, and other staff. [653]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that the interventions for two residents were documented.

Rationale and Summary

A. A resident was at risk for falls.

The resident had a fall and sustained an injury. The post fall assessment documented that a specific intervention was in place at the time of the fall.

In approximately a two-month period, the resident had three falls. The post fall assessments on these days documented the specific intervention was in place. However, this intervention was not documented in the care plan until after the last resident's fall which resulted in an injury.

The DOC said the intervention should have been documented in the plan of care.

By not documenting the intervention in the resident's plan of care, there was potential for staff to not consistently ensure the intervention was in place.

Sources: a resident's clinical records, a critical incident report, and interviews with an RPN and the DOC. [758]

B. A resident had pain related to their medical diagnosis. The resident's pain regimen contained scheduled and as needed medications.

On one occasion it was documented that the resident had pain and their scheduled pain medications were administered. There was no documentation of the location and the pain level, the evaluation of interventions provided and the resident's response.

On a second occasion, the resident had their scheduled pain medications administered before their care. About two hours later, the resident was noted to be in pain. There was no documentation of the location of pain and the pain level, actions taken and the evaluation of the pain interventions, except for indicating that the resident already had their scheduled pain medications administered.

An RPN said that they assessed the resident's pain, but they did not document the assessment and interventions provided as required.

The DOC said that staff should have documented the pain assessment and the evaluation of the pain interventions provided.

Sources: a resident's clinical records, and interviews with an RPN, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a PSW used safe transferring techniques when they assisted a resident with a transfer.

Rationale and Summary

A PSW transferred the resident by themselves.

The physiotherapist said the resident's mobility changed and the resident was not safe to be transferred with one person assistance.

Staff not using safe transferring techniques when assisting the resident with a transfer, put the resident at risk for falls and injury.

Sources: observations of a resident, a resident's clinical records, the home's policy titled Safe Resident Handling, and interviews with a PSW, the physiotherapist, the DOC and other staff. [758]