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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 19, 2024
Inspection Number: 2024-1395-0001
Inspection Type: Critical Incident
Licensee: 2063415 Ontario Limited as General Partner of 2063415 Investment LP
Long Term Care Home and City: Maple Grove Community, Brampton

Lead Inspector	**Inspector Digital Signature**
Diane Schilling (000736)	Diane Schilling Digitally signed by Diane Schilling Date: 2024.01.23 11:02:37 -05'00'

Additional Inspector(s)
Mark Molina (000684)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 11-12 & 15-16, 2024

The following intake(s) were inspected:

- Intake: #00097338 related infectious disease outbreak
- Intake: #00097659 related to fall of a resident with injury
- Intake: #00101824 and Intake: #00101987 related to fall of resident with injury

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

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

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

Directives by Minister

Binding on licensees

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Rationale and Summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023, homes must complete IPAC audits weekly when a home is in COVID-19 outbreak.

An outbreak infectious disease was declared at the home and continued for a period of time. The home was to complete IPAC Self-Assessment Audits but they were not completed four out of the six weeks the home was in outbreak.

Failing to complete the required weekly audits during an outbreak placed residents at potential risk for infection and prolonged outbreak.

Sources: Record review of the home's PHO IPAC Self-Assessment Audits and IPAC Checklist, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario, Interviews with staff
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WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had a fall, all necessary post-fall assessment was conducted using a clinically appropriate assessment instrument that is designed for falls.

Rationale and Summary
A resident had a fall and one of the post fall assessments was not completed.

The Assistance Director of Care (ADOC) stated that the post fall assessment should have been initiated.

Failure to initiate all assessments, put the resident at risk for a delay in identifying any injuries.

Sources: Interviews staff, resident clinical records and policies
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