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: July 19, 2024

Inspection Number: 2024-1395-0003

Inspection Type:
Critical Incident
Follow up

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**
Dianne Tone (000686)	Dianne Elizabeth Tone Digitally signed by Dianne Elizabeth Tone Date: 2024.07.22 15:43:03 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27, 28, 2024 and July 8,-12, 15-17, 2024
The following intake(s) were inspected:
- Intake: #00112841 Related to alleged abuse of a resident
- Intake: #00116958 - Related to alleged abuse of a resident
- Intake: #00117931 - Related to alleged neglect of a resident

The following Order was inspected:
- Intake: #00115249 - Follow-up #: 1 Compliance Order (CO) #001 related to IPAC

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1395-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Dianne Tone (000686)

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The Licensee failed to immediately report alleged abuse of a resident.

Rational and Summary:
A Critical Incident was submitted on May 23, 2024, reporting an allegation of staff to resident abuse that occurred on May 22, 2024.

A Registered Practical Nurse (RPN) documented an incident of alleged abuse on May 22, 2024.

The RPN did not immediately report alleged abuse to the charge Registered Nurse which delayed reporting to the Director.

The Associate Director of Care stated that the alleged abuse was not immediately reported to the Director.

When the home failed to immediately report an allegation of abuse to the Director it may have delayed timely follow up.

Sources: Critical Incident Report, Home investigation notes, resident's clinical record, Interviews with an RPN and an ADOC.

[000686]