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
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 18, 2024

Inspection Number: 2024-1395-0005

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 2-4, 6, 10, 12, 13, 2024
The inspection occurred offsite on the following date(s): December 2, 2024

The following intakes were inspected:

- Intakes #00126796, #00128640, #00130025, #00130336, #00130813, and #00131808, regarding concerns about a resident's care and support services.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure a resident was safely positioned during care. A Critical Incident System (CIS) reported concerns regarding a resident's care.

A resident was to be in a specific position for eating and drinking due to their medical conditions. A Registered Nurse (RN) was administering medication and failed to have the resident in the appropriate position.

The RN acknowledged that they should have put the head of the bed higher before they gave the resident their medication and water.

By not putting the resident in an upright position before giving them a medication and water, put the resident at risk.

Sources: A CIS, a footage of a surveillance video, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure a resident's complaint of pain was reported.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that there is a pain management program to identify pain in residents and manage pain was complied with.

The home's policy "Pain and Symptom Management" said the Personal Support Worker (PSW) will report any resident who verbalized discomfort or pain to the registered staff.

A resident had verbalized to a PSW that they had pain. The PSW said they failed to report the resident's pain to the registered staff. It was not until the following shift when the resident told another PSW of their pain that the resident received pain management.

By not reporting the resident's pain to the registered staff, it delayed follow up to manage the resident's pain.

Sources: A CIS, a resident's clinical records, the home's policy "Pain and Symptom Management", and interviews with staff.[606]