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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Public Report

Report Issue Date: February 21, 2025

Inspection Number: 2025-1395-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 4-7, 11-14, 17-21, 2025.

The following intake(s) were inspected:

- Intake: #00133430, related to resident care and support services, housekeeping, laundry and maintenance services, medication management, safe and secure home, continence care, pain management.
- Intake: #00133495, related to fall prevention and management.
- Intake: #00136579, related to fall prevention and management.
- Intake: #00135313, related to infection prevention and control.

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan. When the resident did not receive the intervention they required for falls prevention and management, they had a fall.

By not following the resident's care plan may have contributed to the reason why the resident fell.

Sources: The resident's care plan, progress notes, and interview with the ADOC.

WRITTEN NOTIFICATION: Medical services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 16
Medical services
s. 16. Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home.

The licensee has failed to ensure that the program for medical services was followed when

laboratory results received by the home were not checked prior to filing in a resident's chart.

In accordance with O. Reg 246/22 s. 11(1)(b) the home is required to ensure there is an organized program of medical services for the home. Specifically, staff did not comply with the home's policy, "Laboratory & Diagnostic Testing, VII-K-10.00", which directs the registered staff to cross reference all reports with the log book, indicating results have been received and sent to the physician; and filed the results in the resident's chart. The resident was provided a medical treatment that was not required for them due to another resident's laboratory result being filed in the resident's chart in error.

By failing to follow the home's policy caused the resident to receive a medical treatment that they did not require and may have caused them discomfort.

Sources: The resident's doctor's orders, medication administration record, and interviews with ADOC #107 and staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident received a weekly skin assessment. By failing to re-assess the resident's altered skin integrity weekly could have delayed interventions required for wound healing.

Sources: The resident's progress notes, and skin and wound evaluations - V6.0

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

(A) The Medical Director's (MD) order stated that the resident was to be administered a medication at a specific time of day however, for 27 days the resident was administered the medication at a different time.

Sources: The resident's progress notes and electronic medication administration report (eMAR), the MD's order, interview with the Director of Care (DOC).

(B) The MD's order stated that the resident was to be administered a medication fives times per day. The DOC stated that this medication is a time-sensitive high alert medication which should be administered within a one hour window, encompassing thirty minutes before up until thirty minutes after the scheduled medication administration time. After review of the resident's clinical records multiple administration times were documented outside of the hour window.

Sources: The MD's Order, Medication Administration Audit Report , CareRx's High Alert and The Medication Pass Policies, Interview with DOC.

(C) The MD's order stated that the resident was to be administered a medication twice daily. The DOC stated that this medication is a time-sensitive high alert medication which should be administered within a one hour window, encompassing thirty minutes before up until thirty minutes after the scheduled medication administration time. After review of the resident's clinical records multiple administration times were documented outside of the hour window.

Sources: The MD's Order, Medication Administration Audit Report July, CareRx's High Alert and The Medication Pass Policies, Interview with DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and was reported to the pharmacy provider. The residents medication was found on the floor in their room. There was no medication incident completed in relation to the omission of the resident's medication and the pharmacy provider was not notified.

Sources: Complaint Record, CareRx's Policy Medication Incident Reporting and associated Appendix O, Types of Medication Incidents, Interview with RPN #108 and DOC.