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

Public Report

Report Issue Date: June 2, 2025

Inspection Number: 2025-1395-0003

Inspection Type:
Complaint
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): May 27-30, 2025

The following intake(s) were inspected:

- Intake: #00144994 - related to prevention of abuse and neglect
- Intake: #00147270, #00147402 - related to fall prevention and management

The following complaint intake(s) were inspected:

- Intake: #00147463 - related to air temperatures and care concerns

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

Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from emotional abuse by a staff member.

In accordance with Ontario Regulation 246/22, s. 2 (1) (a) defines "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was emotionally impacted related to the remarks of a staff member.

Sources: resident's plan of care, the home's internal investigation, interviews.

WRITTEN NOTIFICATION: Licensees Who Report Investigations Under s. 27 (2) of Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged,

suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

A critical incident (CI) reporting an allegation of staff to resident abuse was submitted to the Director, but the CI did not document all of the required information related to the incident that was required by the Director.

Sources: resident's plan of care and interviews.