

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: February 5, 2026

Inspection Number: 2026-1395-0001

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): January 19-23, 27-30 and February 2-4, 2026

The inspection occurred offsite on the following date(s): January 21, 26, 2026

The following intake(s) were inspected:

- Intake: #00160625, related to continence care, nutrition and hydration, infection prevention and control, and prevention of abuse and neglect.
- Intake: #00166422, related to prevention of abuse and neglect, nutrition and hydration, and skin and wound prevention and management.
- Intake: #00165321, related to infection prevention and control.
- Intake: #00165999, related to medication management.
- Intake: #00166955, related to medication management.
- Intake: #00164789, a complaint related to continence care, nutrition and hydration, infection prevention and control, and prevention of abuse and neglect.
- Intake: #00164962, a complaint related to medication management, continence care, and infection prevention and control.
- Intake: #00167420, a complaint related to prevention of abuse and neglect, nutrition and hydration, and skin and wound prevention and management.
- Intake: #00165727, a complaint related to medication management.
- Intake: #00166990, a complaint related to medication management.

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

Skin and Wound Prevention and Management

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

Contenance Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The written complaint record for a resident did not include all required information, including dates actions were taken.

On February 2, 2026, the home provided the missing dates for actions taken.

Sources: The Long-Term Care Homes (LTCHs) written complaint record and interview with Director of Care (DOC).

Date Remedy Implemented: February 2, 2026

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

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

(e) every date on which any response was provided to the complainant and a description of the response; and

The written complaint record for a resident did not include every date on which a response was provided to the complainant or a description of the responses. Specifically, a response provided to the complainant, was not documented, and while a meeting that was held was recorded, a description of the response was not included.

On February 2, 2026, the home provided the missing information regarding dates and responses provided to the complainant.

Sources: The LTCHs written complaint record and interview with DOC.

Date Remedy Implemented: February 2, 2026

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

Nursing staff documented ongoing signs and symptoms of infection at a resident's treatment site following completion of prescribed topical antibiotic therapy. These findings were not communicated to the Nurse Practitioner or Physician in a timely manner, resulting in a delay in further assessment and treatment.

Sources: The resident's clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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

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.

Barrier cream was applied to a resident despite documentation indicating that the product was on hold while another prescribed treatment was ongoing.

Sources: The resident's clinical health records, the LTCHs internal investigation, interview with DOC.

WRITTEN NOTIFICATION: Pain management

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

Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

A PRN pain medication was administered to a resident without documented reassessment of the resident's response to or the effectiveness of the medication.

Sources: The resident's clinical health records, LTCH policies, and interviews with staff.

WRITTEN NOTIFICATION: Weight changes

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 75 2.

Weight changes

s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

2. A change of 7.5 per cent of body weight, or more, over three months.

A resident was not assessed using an interdisciplinary approach and actions were not taken when they experienced a 10.7 per cent loss of body weight over a three month period.

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

Sources: Monitoring of Resident Weights Policy, Referral to Registered Dietitian and/or Director of Dietary Services Policy, Point Click Care (PCC) Weight and Summary Alerts, interviews with the Registered Dietitian (RD) and other staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

In accordance with the Infection Prevention and Control Standard for Long-Term Care Homes, infection monitoring was not completed and documented on every shift for a resident with an active infection.

Sources: The resident's clinical health records, LTCH Policy, IPAC Standard for Long-Term Care Homes, and interviews with staff.

WRITTEN NOTIFICATION: Medication management system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A prescriber's order included a special instruction to withhold a topical product during treatment; however, the instruction was not transcribed to the electronic medication administration record (eMAR), resulting in the record not fully reflecting the order.

Sources: The resident's clinical health records, LTCH policy, and interviews with staff.

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

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Complete a root-cause analysis to determine what circumstances may have led to the resident's fluid intake not being monitored by staff.

a) From the analysis, determine gaps in processes and create an action plan to address those gaps.

b) Maintain detailed documentation of the root-cause analysis, action plan, and implementation of the action plan, including when and who was involved in the implementation.

2) Review the Hydration and Nutrition Monitoring Policy based on the results of the root-cause analysis, to determine if any updates are required.

3) Review the grounds of this compliance order, as well as the results of the root-cause analysis with the home's staff. During this review, provide re-education on the Hydration and Nutrition Monitoring Policy (if any changes were made). This review must include the following and be made available upon the Inspector's request: signature(s) of the educator(s), signature(s) of the attendees, the date(s) of the education, and the content(s) provided.

4) Implement an auditing process to ensure that staff are monitoring and evaluating resident fluid intakes as per the home's Hydration and Nutrition Monitoring Policy. The

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

audits must be completed once per week for a minimum of four weeks or longer if continued concerns are identified.

5) Maintain a record of the audits at the home. Ensure that it includes the following and be made available upon the Inspector's request: names of the auditor and persons being audited, the dates, and corrective actions taken (if any).

Grounds

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nutritional and hydration program were complied with. Specifically, the home's nutritional care and hydration policy indicated that all residents' fluid intake were to be documented and monitored daily, which did not occur for a resident.

A resident's fluid intake was not consistently monitored by staff for an extended period of time and there were no assessments or referrals initiated to address their fluid intake status. As a result, the resident's fluid intake records were not reviewed or evaluated by the health care team in a timely manner.

When staff were not monitoring the resident's daily fluid intake, there was a high risk of the resident not meeting their hydration requirements.

Sources: Hydration & Nutrition Monitoring Policy, Referral to Registered Dietitian and/or Director of Dietary Services Policy, Progress Notes, Fluid Intake Look Back Reports, Complex Alert Documentation Report, Investigation Notes, PCC Weight and Summary Alerts, interviews with the RD and multiple staff.

This order must be complied with by March 30, 2026

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.



Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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