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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 25, 2025
Inspection Number: 2025-1068-0003
Inspection Type: Critical Incident
Licensee: Better Life LTC Inc.
Long Term Care Home and City: Maple Villa Long Term Care Centre, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 19, 20, 23-24, 2025

The following intake(s) were inspected:

- Intake: #00146111 - 2408-000003-25 - Fall Prevention and Management

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

Skin and Wound Prevention and Management
Falls Prevention and Management

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: 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 for fall prevention and management.

Two fall prevention strategies that were identified in the resident's plan of care were not in place when the resident was observed by the Inspector on June 12, 2025. Staff acknowledged the strategies were not in place and implemented the strategies when it was brought to their attention. The strategies were in place when observed a second time and the resident's plan of care was also revised.

Sources: clinical health record of the resident; observation of the resident; interview with staff.

Date Remedy Implemented: June 19, 2025

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff applied a resident's assistive device in accordance with manufacturer's instructions.

Staff did not apply a resident's device correctly, resulting in skin impairment. The Physiotherapist stated that directions for the correct application of the device were available for staff. The Registered Nurse (RN) stated the manufacturer's directions went missing and were reprinted and posted after the skin impairment was identified.

Sources: clinical health record for the resident; interview with RN and Physiotherapist.

WRITTEN NOTIFICATION: Required programs

NC #003 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 the pain management program was followed for a resident.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a pain management program to identify and manage pain in residents, and that it was complied with. Specifically, staff did not comply with the "Pain Management & Assessment" policy, which required staff to complete a Risk-Pain Assessment progress note when a resident had a pain level

of four or more.

A resident had a pain level of four or more identified on four dates and a Risk-Pain Assessment progress note was not completed. The Registered Nurse (RN) acknowledged that the progress notes were not completed as per the home's policy and physician order.

Sources: clinical health record for a resident; interview with RN.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 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 that a resident, who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Weekly skin assessments were incomplete for multiple areas of skin impairment. A Registered Nurse (RN) acknowledged that not all required weekly wound assessments were completed for the areas of skin impairment.

Sources: clinical health record for a resident; interview with RN.

WRITTEN NOTIFICATION: Resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

a) Head injury routines (HIR) had been completed and were in the resident's clinical health record, however, the records had not been dated. It was not clear which date(s) the records were for. A Registered Practical Nurse (RPN) acknowledged the records were not dated and confirmed that staff were to include a date on each record.

Sources: clinical health record for a resident; interview with RPN.

b) Multiple staff identified that a resident had a history of a particular behaviour, however, there was no documentation of the behaviour in the resident's clinical record until after a negative outcome. Registered Nurse (RN) stated that staff communicated verbally about the behaviour, however, acknowledged that the communication should have been documented in the resident's progress notes.

Sources: clinical health record for a resident; interview with RNs, and RPN.

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