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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 5, 2023
Inspection Number: 2023-1213-0002
Inspection Type: Critical Incident System
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Maplewood, Brighton

Lead Inspector	**Inspector Digital Signature**
Carrie Deline (740788)	Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.05.09 12:24:00 -04'00'

Additional Inspector(s)
Polly Gray-Pattemore (740790)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1 - 4, 2023

The following intake(s) were inspected:

- Intake: #00009198 - CIR# - 2717-000014-22; Intake #00014945 - CIR# - 2717-000020-22; Intake #00015596 – CIR# 2717-000022-22 Missing/unaccounted for Controlled Substance
- Intake: #00016695 - CIR# - 2717-000023-22: Environmental Hazard Flooding.
- Intake: #00020021 - CIR# - 2717-000006-23: Medication incident involving a resident.
- Intake: #00021435 - CIR# - 2717-000009-23: Unexpected Death of a resident.
- Intake: #00084388 - CIR# - 2717-000012-23: Improper care of staff to resident resulting injury.

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

Continence Care
Medication Management
Infection Prevention and Control
Safe and Secure Home
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)

The licensee failed to ensure that transferring of the resident was completed as set out in the resident's plan of care.

Rationale & Summary

A review of a resident's current plan of care indicated that the resident was to be transferred with two staff assistance. A CIR was submitted with notification that a staff member had transferred a resident from bed to wheelchair with only one staff member.

Interviews with staff confirmed that the resident does require two staff assistance for all transferring.

Failure to follow a resident's plan of care places a resident at risk for not being provided the care they require.

Sources:

Resident progress notes and care plan; CIR 2717-000012-23, resident observations, and interviews with Administrator, RAI Coordinator, and PSW's
[740788]