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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 08, 2024	
Inspection Number: 2024-1213-0001	
Inspection Type: Critical Incident	
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 Stephanie Fitzgerald (741726)	Inspector Digital Signature Stephanie A Fitzgerald Digitally signed by Stephanie A Fitzgerald Date: 2024.02.08 13:01:20 -05'00'
Additional Inspector(s	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29-31, 2024 and February 1, 2, 5, and 6, 2024

The following intake(s) were inspected:

- Intake: #00097096 / Critical Incident (CI) #2717-000022-23 Fall of resident, resulting in injury
- Intake: #00101404 / CI #2717-000025-23 - Fall of resident, resulting in injury
- Intake: #00103643 – CI #2717-000026-23 - alleged Improper / Incompetent treatment of resident

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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, related to bed mobility, was provided to them, as specified in the plan.

Rationale and Summary
On a specified day in December, 2023, a resident was being repositioned in bed, when they sustained a fall with injury.

A review of the resident's care plan and kardex, indicated two staff are required for all bed mobility.

During an review of the resident's progress notes, it was documented that one staff member was present during care being provided.

During interviews with staff and Administrator, it was confirmed that the resident required two staff for all bed mobility and care, and only one staff member was present at the time of the incident. It was confirmed that the care for the resident was not provided to them, as specified in the plan.

When the plan of care for the resident, related to bed mobility, was not complied with, as specified in the plan, injury occurred.

Sources: Resident's electronic care plan, kardex, and progress notes. Interviews with staff and Administrator #101. [741726]