

# 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

|   | Original Public Report      |
|---|-----------------------------|
| Report Issue Date: October 17, 2023   |                             |
| Inspection Number: 2023-1395-0004   |                             |
| Inspection Type: Critical Incident  |                             |
| Licensee: 2063415 Ontario Limited as General Partner of 2063415 Investment LP |                             |
| Long Term Care Home and City: Maple Grove Community, Brampton                 |                             |
| Lead Inspector  | Inspector Digital Signature |
| Kailee Bercowski (000734)   |                             |
|   |                             |
| Additional Inspector(s)   |                             |
| Craig Michie (000690)   |                             |
|   |                             |

### **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): October 10-13, & 16, 2023

The following intake(s) were inspected:

- Intake: #00091761, CI #2911-000023-23 related to a resident's fall.
- Intake: #00093769, CI #2911-000028-23 related to resident care during meal service.

Inspector Kristen Owen #741123 was present during this inspection.

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

Food, Nutrition and Hydration Infection Prevention and Control Falls Prevention and Management



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### **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 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised when their care needs changed.

#### **Rationale and Summary**

A Registered Nurse (RN) said frontline staff would refer to residents' care plans to determine what assistance to provide at mealtime.

A resident's plan of care was not revised until six days after their needs changed, when it was also updated with their increased risk of choking.

When the resident's plan of care was not revised to reflect their changed assistance needs, they were at risk to receive insufficient mealtime assistance.

**Sources:** Interviews with staff; Resident's clinical records, and a critical incident report. [000734]