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

Central West District
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Original Public Report

Report Issue Date: November 13, 2024

Inspection Number: 2024-1395-0004

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): October 1-4, 7-11, 15-17, and 23, 2024.
The inspection occurred offsite on the following date(s): October 16, 2024

The following Critical Incident System (CIS) intakes were inspected:

- Intakes #00120004, #00121375, #00128959, and #00126936 regarding an allegation of staff to resident abuse.
- intake #00120721 regarding the home's Skin and Wound Program, and
- intake #00125733 regarding the home's Falls Prevention and Management Program

The following Complaint Intake was inspected:

- Intake #00127599 regarding concerns about a resident's care.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 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's wound were assessed weekly.

Rationale and Summary:

A resident had an altered skin integrity.

Several of the resident's skin and wound evaluations were incomplete and did not

include the information required in the assessment including the wound's measurements, presence of edema, odour, pain or assessing for signs and symptoms infection.

Two Registered Practical Nurses (RPN) and a Registered Nurse (RN) said that when conducting a weekly skin and wound assessment, all sections of the assessment should be completed.

Failure to complete weekly assessments to include the wound's measurements, presence of edema, odour, pain or assessing for signs and symptoms of infection may have delayed appropriate follow up for the resident's skin care.

Sources: a resident's Skin and Wound Evaluations, progress notes, and care plans, and interviews with staff. [606]

WRITTEN NOTIFICATION: Residents Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure a resident received privacy during care. Specifically, staff did not ensure a resident's body was covered up to keep the resident warm and maintain privacy and prevent embarrassment.

Rationale and Summary:

The home received a concern that resident did not receive privacy during care.

Interviews with a PSW and an RPN acknowledged that during care, staff should ensure the resident is covered as much as possible and only expose the area being provided care to.

Failure to follow cover a resident's body during care may have caused the resident discomfort.

Sources: a resident's clinical records, the home's investigation records, and interviews with staff.[606]

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 a resident's plan of care was provided as specified in the plan.

Rationale and Summary:

During a day shift, a Personal Support Worker (PSW) assisted a resident in a manner that was not aligned with their plan of care. After the care was completed, the

resident alleged that the PSW hurt them and caused them to sustain an injury.

An Associate Director of Care (ADOC) said staff should have followed the resident's plan of care to ensure care was provided appropriately.

Not following the resident's plan of care may have contributed to the resident's injury.

Sources: a critical incident (CI). A resident's progress notes and care plan, the home's investigative notes and interviews with a PSW, an ADOC, and other staff [758]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented.

Rationale and Summary

During a day shift, a PSW provided a resident care.

There was no documentation of the care provided by the PSW during that day shift.

An ADOC said the care provided to the resident by the PSW should have been documented in the resident's Point of Care (POC).

Gaps in the documentation of the care provided to the resident made difficult to evaluate the effectiveness of care and ensure continuity of care.

Sources: a resident's documentation survey report v2. and interviews with a PSW and an ADOC.[758]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident.

Rationale and Summary

The home submitted a Critical Incident (CI) to the Ministry of Long-Term Care (MLTC) related to allegations of physical abuse of a resident by a PSW.

A resident reported to a Registered Practical Nurse that a PSW caused them pain and an injury. The resident reported the same concerns to an RN. Prior to these allegations, the resident was assisted with care by two PSWs.

The home's investigation notes did not include any written statements of staff who were aware or involved in the incident or any interviews by staff who had knowledge of the incident.

An Associate Director of Care (ADOC) acknowledged that the investigation procedure was not followed as indicated in the home's policy to promote zero tolerance of abuse and neglect of residents when investigating the allegations of abuse made by a resident.

By not following the home's investigation process for alleged abuse of a resident as indicated in the home's Prevention of Abuse and Neglect policy, essential information about the incident may be missed which could result in a delay in implementing appropriate interventions.

Sources: a critical incident report, a resident's progress notes, the home's investigation notes, the home's policy, Prevention of Abuse & Neglect of a Resident, and interviews with an ADOC and other staff. [758]

WRITTEN NOTIFICATION: Reports of investigation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of an investigation related to allegations of abuse of a resident were reported to the Director.

Rationale and Summary:

Allegations of abuse of by a resident by a PSW were reported to the MLTC and a CI was submitted related to the same allegations.

The results of the investigation were not reported to the Director.

An ADOC said the CI was not amended to include the results of the investigation, as required.

Failing to report to the Director the results of the investigation of the allegations of abuse of resident #002, limited the Director's ability to respond to the incident in a timely manner, if required.

Sources: a critical incident report and an interview with an ADOC. [758]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when staff had reasonable grounds to suspect that an abuse had occurred, that they immediately reported the suspicion and the information upon which it was based on to the Director.

Pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary:

A resident expressed concerns to a staff member related to feeling neglected and abused by staff.

The staff member said they did not immediately inform the Charge Nurse or the manager on call about the incident, but they sent an email to the Director of Resident Programs (DRP). The incident was not reported to the Director until the DRP retrieved their emails.

An ADOC said the incident was not reported as required.

By not reporting allegations of abuse of a resident immediately to the Director, it limited the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report. a resident's progress notes, the home's investigation notes and interviews with an ADOC and other staff. [758]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure staff used safe transferring techniques when they assisted a resident with their transfers.

Rationale and Summary:

A resident was transferred in a manner that did not align with their plan of care.

Three PSWs said that on multiple occasions when transferring the resident prior to the incident, the resident would refuse the appropriate transfer method.

Consequently, the PSWs would transfer the resident in a manner that did not align with their plan of care.

The home's Physiotherapist said this transfer method was not a safe transferring technique due to risk of injuries to the resident and staff.

Staff not using safe transferring techniques when assisting a resident with transfers, put the resident at risk for injury.

Sources: a resident's progress notes, care plan, physiotherapy assessments, the home's investigation notes, the home's policy, and interviews with PSWs, #127, a PT, an ADOC and the DOC. [758]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Rationale and Summary:

A resident reported that they sustained an altered skin integrity after a PSW provided care to them. The resident was noted with an altered skin integrity.

A Head-to-toe skin assessment was completed on the same day, however it documented that there were no alterations in the skin integrity.

An ADOC and an RPN said when a resident had an intact skin alteration, a skin and wound evaluation assessment should be completed, and a picture of the area should be taken. The area was to be monitored and re-assessed until resolved.

Not completing a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment, made it difficult to monitor and re-assess the resident's altered skin integrity.

Sources: a critical incident report, a resident's progress notes, head-to-toe skin assessment, and interviews with an RPN and an ADOC and other staff.[758]