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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: March 13, 2025

Inspection Number: 2025-1600-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Regional Municipality of York

Long Term Care Home and City: York Region Maple Health Centre, Maple

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 10, 11, 12, 13, 2025

The following intake(s) were inspected:

- One intake related to an allegation of physical abuse,
- One intake related to a follow-up from a compliance order, and
- One intake related to a complaint regarding medication administration.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1600-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Medication 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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee had failed to ensure that the plan of care for a resident was reassessed and the plan of care reviewed and revised at least every six months or at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident Report (CIR) was submitted to the Director, related to an allegation of physical abuse.

The Director of Care (DOC) indicated that the plan of care was not revised after the incident. Furthermore, the current interventions that were in place for the resident to

prevent a reoccurrence were also not added to the plan of care.

The plan of care for the resident had been revised during this inspection to reflect the care needs and current interventions.

Sources: Record review of clinical chart, investigation file, Critical Incident Report, observation of the resident, and interviews with the Director of Care, and other staff. [647]

Date Remedy Implemented: March 12, 2025

WRITTEN NOTIFICATION: Consent

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7
Consent
s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

The licensee had failed to ensure they received the consent from resident's Substitute Decision Maker (SDM) before administering a medication for two consecutive days.

A complaint had been received by the Director regarding the administration of a medication without obtaining the consent of the SDM.
A review of the resident's clinical file indicated that a medication order was written by the Physician. The SDM was contacted to provide consent, however the SDM did not consent to the administration of the new medication. A review of the medication administration record (MAR) indicated that the resident received this medication for two consecutive days.

Sources: Written complaint, clinical health records, investigation file, interviews with the complainant, DOC and other staff. [647]

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