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: August 25, 2025
Inspection Number: 2025-1600-0005
Inspection Type: Complaint
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): August 20-22, and 25, 2025.

The following intake(s) were inspected:

- Intake- related to a resident's care services, and responsive behavior.
- Intake-related to a resident's fall.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee failed to ensure that actions were taken to respond to the needs of a resident, including resident's monitoring and internal reporting protocol.

A review of resident's records indicated a consistent behavioral pattern which require further assessment. A referral to Behavioral Support Ontario (BSO) was initiated; however, the referral was not processed.

During an interview with the Behavioral Supports Ontario Registered Practical Nurse (BSO RPN), it was confirmed that the referral had been submitted but was inadvertently missed.

Sources: Resident's health records, and staff interview.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that actions taken to respond to the need of resident, including assessment, were documented.

A review of the resident's health records indicated that a behavior tracking form was to be completed with the purpose of monitoring the resident's behavior during a specified time period. When reviewed, multiple sections of the form were not charted as required.

Sources: Resident's health records, and staff interview.

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