Ontario

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

Public Report

Report Issue Date: March 4, 2025
Inspection Number: 2025-1239-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Holland Christian Homes Inc.
Long Term Care Home and City: Faith Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 11-14, 18-21, 24-28, and March 4, 2025
The inspection occurred offsite on the following dates February 13, and 24, 2025

The following intake was inspected:
- Intake #00139309, Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain 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 has failed to ensure that a resident's plan of care was reviewed and revised when one of their falls prevention interventions was no longer required.

On February 27, 2025, the resident's plan of care was updated, and the falls intervention was discontinued.

Sources: a resident's plan of care and an interview with a Registered Practical Nurse (RPN).

Date Remedy Implemented: February 28, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius. On one occasion, the air temperature was below 22 degrees on the area adjacent to the entrance to three of the Resident Home Areas.

On the same day, the temperature on the above indicated areas was adjusted to remain above 22 degrees Celsius.

Sources: LTCH's observations and an interview with the Director of Resident Care (DRC)

Date Remedy Implemented: February 18, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the written record of the home's Skin and Wound Care, Pain Management Program and Staffing Plan program evaluations for 2024 included the date of the evaluation, the persons who participated in the evaluation and the dates when changes to the programs were made.

A. On February 27, 2025, the home's Skin and Wound and Pain Management evaluations for 2024, were updated to include the required information.

Sources: the home's Skin and Wound Care, and Pain Management program annual evaluations (2024), and an interview with the Administrator.

B. On February 28, 2025, the home's Annual Staffing Plan evaluation for 2024 was updated to include the required information.

Sources: the home's Staffing Plan program evaluation (2024) and an interview with the Administrator.

Date Remedy Implemented: February 28, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the additional screening requirement under section 11.6 of the Infection Prevention and Control (IPAC) Standard issued by the Director was followed.

Specifically, the licensee has failed to ensure that signage that listed the signs and symptoms of infectious diseases for self-monitoring was posted throughout the home.

On February 14, 2025, signage that listed the signs and symptoms of infectious diseases for self-monitoring was posted on the entrance door of each Resident Home Area, in addition to the home's main entrance.

Sources: Long-Term Care Homes Inspector's observations, IPAC Standard (2023) and an interview with the IPAC Lead.

Date Remedy Implemented: February 14, 2025

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that their Continuous Quality Improvement (CQI) initiative report for 2024-2025 included all the dates when actions taken based on the results of the residents' and family surveys were implemented and the outcome of these actions.

On February 24, 2025, all the dates of the actions taken and the outcome of these actions were updated on the CQI report.

Sources: the home's CQI report 2024-2025, and interviews with the Administrator/CQI Lead.

Date Remedy Implemented: February 24, 2025

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that their Continuous Quality Improvement (CQI) initiative report for 2024-2025 included the dates when any actions were taken in the home's priority areas for quality improvement.

On February 27, 2025, the home's CQI report was updated with the required dates.

Sources: the home's CQI report 2024-2025, and interviews with the Administrator/CQI Lead.

Date Remedy Implemented: February 27, 2025

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their CQI initiative report for 2024-2025 included a written record of how and the dates when actions taken based on the results of the residents' and family surveys and the home's priority areas for quality improvement were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

On February 27, 2025, the CQI report was updated to include the required information.

Sources: the home's CQI report 2024-2025, and interviews with the Administrator/CQI Lead.

Date Remedy Implemented: February 27, 2025

WRITTEN NOTIFICATION: Doors in a home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that two doors leading to non-residential areas were kept locked when not supervised by staff. On one occasion, two soiled utility room doors located in different RHAs were left unlocked and were not supervised by staff. When the doors were left unlocked, it could have resulted in residents accessing these non-residential areas of the home.

Sources: Long-Term Care Homes (LTCH) Inspector's observations, and interviews with a Personal Support Worker (PSW), an RPN, and the DRC.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee has failed to ensure that when a resident self-administered part of their medications, the administration was approved by the prescriber. On one occasion, during a medication pass, an RPN left at the resident's bedside several medications for self-administration. There was no approval from the resident's physician for self-administration of medication. When the resident was left to self-administer part of their medications without the prescriber's approval, there was a risk that medications may not be administered as prescribed.

Sources: LTCH Inspector's observation, a resident's clinical records, the home's Self-Administration of Medication policy, and interview with an RPN, a Team Lead and the DRC.