

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2020	2020_781729_0008	009681-20, 010258-20	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

Long-Term Care Home/Foyer de soins de longue durée

Grace Manor
45 Kingnoll Drive BRAMPTON ON L6Y 5P2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KIM BYBERG (729), AMANDA OWEN (738)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 14, 15, 19 - 21, 25 - 29, 31, June 1, 2, 4, 5, 8 - 11, 15 -18, 2020, as an off-site and on-site inspection.

The following intakes were completed within the Critical Incident inspection:

**Log # 009681-20 related of transferring and positioning;
Log # 010258-20 related to fall prevention.**

This inspection was completed concurrently with the Complaint Inspection #2020_781729_0007.

PLEASE NOTE: A written notification related to LTCHA, 2007, c.8, r. 50. (2) (b) (iv) as identified in this inspection and has been issued in complaint inspection report #2020_781729_0007, dated July 9, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator (RAI), Dietary Manager, Dietitian, Housekeeping/Laundry Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency RPN, Agency PSW, Housekeeping, Physiotherapy Assistant, Canadian Armed Forces (CAF), Residents and Families.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed meal service, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, employee files, education records, home's investigation notes; and observed the general maintenance, cleanliness, safety and condition of the home.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

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,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011's plan of care was reviewed and revised when their care needs changed or care set out in the plan of care was no longer necessary.

Resident #011's care plan, documented the resident had specified toileting interventions in place with the assistance of one staff member.

RPN #108 and PSW #136 stated that resident #011 was transferred using an identified intervention.

A physiotherapy documented on a specified date stated that resident #011 required a specific intervention for toileting.

The care plan was not updated to indicate the required intervention.

The licensee has failed to ensure that resident #011's plan of care was reviewed and revised when their care needs changed or care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that safe transferring and positioning devices or techniques were used when transferring resident #025.

Agency PSW #134 said they transferred resident #025 to the toilet using an assistive device with a regular staff member on specified dates. They said they were not sure what the resident's care plan indicated for toileting or if they had access to the care plan.

A progress note titled physiotherapy, documented on a specified date the resident could not be toileted using the assistive device.

Resident #025's care plan showed on a specified date, toileting was put on hold.

RAI Coordinator #131 and PSWs #132 and #133 stated that resident #025 was toileted in bed due to a specified injury. They said the resident should not have been transferred with the use of the assistive device.

The licensee has failed to ensure that resident #025 was transferred using safe transfer techniques. [s. 36.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing
assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to toilet resident #025.

During an interview, resident #025 told Inspector #738 that staff would tell them to go to the bathroom in a specified manner. They said they did not like doing this and that staff did not offer them an alternative method for using the toilet.

PSW #133 and #114 and RPN #112, said they did not offer an alternative method for toileting.

The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to toilet resident #025. [s. 51. (2) (e)]

Issued on this 13th day of July, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.