Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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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
Apr 12, 2021	2021_826606_0009	025490-20, 002322-21	Complaint

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 Kingknoll Drive Brampton ON L6Y 5P2

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 8-11, and 16, 2021.

The following intakes were completed in this Complaint inspection:

Log #002322-21 was related to an allegation of resident abuse and neglect; and log #025490-20 was related to admission and discharge.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Physician, Registered Dietitian (RD), Dietary Manager (DM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Recreation Aides (RA), Housekeeping Staff and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector observed resident and staff interactions, provision of care, infection control practices, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure the fluid intake was documented for three residents reviewed.

A resident was transferred to the hospital due to a change in their condition and passed away while at the hospital. A complaint alleged the resident was dehydrated when they were transferred to the hospital due to staff neglect.

Three residents were identified at risk for dehydration and required a specified amount of fluids daily. Staff were told to provide the residents fluids during meals, nourishment, and at other times during the 24 hour period and document the amount of fluids the resident consumed. This was acknowledged by a Registered Practical Nurse (RPN), the Dietary Manager(DM) and Administrator.

The residents’ clinical records were reviewed and showed their fluid intake was not documented on numerous dates and times.

Failing to document the residents' fluid intake may cause inaccuracy in evaluating the residents’ care and could potentially put the residents at risk for dehydration.

Sources: Complaint report to the Ministry of Health and Long Term Care, an identified Home's policy, residents’ clinical records and interviews with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

Issued on this 15th day of April, 2021

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

Original report signed by the inspector.