Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
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Original Public Report

Report Issue Date August 4, 2022
Inspection Number 2022_1426_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Holland Christian Homes Inc.

Long-Term Care Home and City
Grace Manor, Brampton

Lead Inspector **Inspector Digital Signature**
Janet Groux #606

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 5-8, 11-14,18, and 21, 2022.

The following intake was inspected:

- Intake #010276-22 regarding the home's falls prevention and management program, medication management system, skin and wound program, staff training and orientation, food preferences, resident abuse, and whistle-blowing protection and retaliation.

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

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WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 54(2)

The licensee failed to ensure a resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:

The home's "Falls Prevention and Management Program", defined a fall as "any unintentional change in position where the resident ends up on the floor, ground or other lower level".

A resident fell after they slid out of a transfer device. Two Personal Support Workers (PSW) held on to the resident as they were falling and lowered the resident to the floor.

A Registered Practical Nurse (RPN) acknowledged they did not initiate a post fall assessment because they did not consider the incident a fall.

Failure to complete a post fall assessment, which includes identifying factors that may have caused the fall, put the resident at risk of falls.

Sources: the home's Fall Prevention and Management Program, a resident's progress notes, fall prevention and management care plan, and interviews with staff.

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure safe transferring and positioning techniques were used when a resident was transferred.

Rationale and Summary:

A resident fell when they slid out of a transfer device during a transfer.

A Registered Practical Nurse (RPN) said the two PSWs reported they were transferring the resident when the resident began sliding. The PSWs said they caught the resident and slowly lowered them to the floor. The RPN said one of the PSWs told them that the other PSW did not properly apply the transfer device on the resident.

Failure to apply a transfer device correctly caused the resident to fall and could have injured the resident.

Sources: a resident's progress notes, care plan, and interviews with staff. (606)

WRITTEN NOTIFICATION: PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTC 2021 s. 6(1)(c)

The licensee failed to ensure that a resident's care plan for transferring sets clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:

A resident fell after they slid out of a transfer device during a transfer.

The resident's care plan said the resident required two staff assist for their transfers with a specific type of transfer equipment. The care plan did not identify the specific transfer device to use for the resident.

The home's lift and transfer lead, acknowledged that the resident's care plan did not identify the specific transfer device required for staff to use with the specified transfer equipment.

Failure to ensure the specific transfer device for the resident was used caused the resident to slide out and fall.

Sources: a resident's progress notes, care plans, and interviews with staff. (606)

WRITTEN NOTIFICATION: NOTIFICATION RE: CRITICAL INCIDENTS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 115(4)(b)

The licensee has failed to ensure a critical incident system (CIS) report was submitted to the Director of the Ministry of Long Term Care (MLTC).

Rationale and Summary:

A resident was transferred to the hospital after they fell, and was diagnosed with an injury.

After the fall, the resident was assessed with a significant change in their status and required more assistance with their care.

The Director of Resident Care (DRC) acknowledged that a CIS report was not submitted to the Director for the resident's fall.

Sources: a resident's progress notes, RAI-MDS assessments, and interviews with staff. (606)