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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 28, 2023	
Inspection Number: 2023-1426-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Holland Christian Homes Inc.	
Long Term Care Home and City: Grace Manor, Brampton	
Lead Inspector Brittany Nielsen (705769)	**Inspector Digital Signature** Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2023.10.10 13:46:57 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 23-25, 28-31, September 1, 2023

The following intake(s) were inspected:

- Intake: #00092286 complaint related to resident neglect, continence care and bowel management, and falls prevention and management
- Intake: #00092913 related to improper transfer of a resident
- Intake: #00095169 complaint related to falls prevention and management, and resident neglect

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

Resident Care and Support Services
Whistle-blowing Protection and Retaliation
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure that a resident's rights to be afforded privacy in treatment and in caring for their personal needs was fully respected.

Rationale and Summary
A staff member took a picture of a resident using their personal cell phone and sent it to someone through a text message.

The Director of Care (DOC) stated that this was a breach of the home's confidentiality and privacy agreement.

By taking a photo of a resident and sending the photo through a text message, there was a violation to the resident's privacy and there was risk of violating confidentiality.

Sources: interviews with staff and the resident's family, record review of the home's Confidentiality and Privacy agreement and the photos sent.

[705769]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 that staff used safe transfer techniques when assisting a resident while using a mechanical lift.

Rationale and Summary
A staff member transferred a resident using a mechanical lift with no other staff present. The resident's plan of care indicated they are two staff total assistance when transferring with the lift. While the staff

member was transferring the resident, the resident was injured.

Staff said that there should always be two staff present while transferring a resident using a mechanical lift.

By failing to use proper transferring techniques, the resident was injured.

Sources: critical incident report, home's investigation notes, a resident's plan of care, interviews with staff.

[705769]