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

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Original Public Report

Report Issue Date: September 12, 2024
Inspection Number: 2024-1426-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Holland Christian Homes Inc.
Long Term Care Home and City: Grace Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates (s): July 22-25, 29-31, 2024 and August 1-2, 2024.

The following intake(s) were inspected:

- Intake: #00115644, Follow-up CO #001, related to prevention of abuse and neglect.
- Intake: #00115214, CI#2942-000012-24, related to falls prevention and management.
- Intake: #00117715, CI#2942-000015-24, related to resident care and support services.
- Intake: #00119562, CI#2942-000019-24, related to infection prevention and control.

- Intake: #00117892, a complaint related to resident care and support services.

The following intake was completed in this inspection:

- Intake: #00120238, CI#2942-000021-24, related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1426-0001 related to FLTCA, 2021, s. 24 (1) inspected by Craig Michie (000690)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Non-Compliance with O. Reg. 246/22, s. 40

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A resident was transferred in a manner that was not aligned with their assessed needs.

The PSW failed to ensure that safe techniques were used when transferring a resident, which may have put the resident at risk of injury.

Sources:
The resident's clinical records, Critical Incident report, internal investigation documentation and interviews with staff.
[000690]

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their falls prevention and management

program by ensuring that a fall risk assessment was completed for a resident after their fall when their mobility and transfer status changed.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their falls prevention and management program, at a minimum, provides for strategies to reduce or mitigate falls. Specifically, staff did not comply with the home's "Fall Prevention and Management Program" policy which specified that the Registered Nurse (RN) or Registered Practical Nurse (RPN) complete a fall risk assessment with any significant change in resident status.

Rationale & Summary

A resident had a fall and a fall risk assessment was not completed until 19 days after their fall.

The Falls Lead acknowledged that a fall risk assessment should've been completed sooner after the residents fall. They confirmed the home became aware of the resident's injury and change in transfer status six days after the residents fall.

When the resident did not receive a fall risk assessment after a significant change in their status following a fall, there was risk of staff being uninformed about changes to the resident's risk level and taking action accordingly.

Sources:
Record review for the resident, review of the home's Fall Prevention and Management Program Policy, FP-01, revised April 22, 2024, and interview with the Falls Lead.
[000685]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to comply with their pain management program when both an initial and follow up pain assessment was not completed for a resident after the resident demonstrated signs of pain a day after having a fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their pain management program, at a minimum, provides for communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. Specifically, staff did not comply with the home's "Pain Management" policy which stated that a PAINAD assessment should be completed for residents with cognitive impairment or who are unable to self-report.

Rationale & Summary

A resident had a fall and a pain assessment was completed at the time of their fall. A registered staff member was notified that the resident appeared to be in pain. Medication was administered however an initial pain assessment was not completed, nor a follow up pain assessment, as required by the home's policy. The resident continued to have changes in their physical abilities related to pain.

The Falls Lead confirmed that a pain assessment should've been completed, when

the registered staff member was informed that the resident was having pain. They also acknowledged that direct care staff should've been more diligent in assessing, documenting and reporting the resident's pain and change in status to the physician.

When the registered staff member did not complete a clinically appropriate pain assessment after being informed that a resident was in pain, it put the resident at risk of further discomfort and potential undiagnosed injury from their fall.

Sources:
A record review of the resident, review of the home's Pain Management Program Policy, CNS-00-15-02, revised April 22, 2024, and interview with the Falls Lead. [000685]