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
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 15, 2022
Inspection Number: 2022-1426-0002
Inspection Type: District Initiated Complaint Critical Incident
Licensee: Holland Christian Homes Inc.
Long Term Care Home and City: Grace Manor, Brampton

Lead Inspector	**Inspector Digital Signature**
Jessica Bertrand (722374)	Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2022.12.20 10:24:05 -05'00'

Additional Inspector(s)
Janis Shkilnyk (706119)
Craig Michie (000690) was also present during the inspection.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 1-4, 7-8, 2022 and off-site on November 21, 2022.

The following intakes were completed in this inspection:

- Intake #00011499 (complaint) related to resident care and pain management.
- Intake #00011650 (Critical Incident System (CIS) #2942-000011-22) related to complaints procedure.
- Intake #00012521 (district-initiated) related to resident care and services and safe and secure home.

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

Food, Nutrition and Hydration
Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION Complaints Procedure - Licensee

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee failed to ensure that when a written complaint concerning the care of a resident was received by the home, the Director was notified immediately.

Rationale and Summary
An injury of unknown origin was discovered on a resident and reported by staff.

The management team received an email two days after the discovery alleging that the injury was the result of improper/incompetent care. An internal investigation commenced at that time; however, the home did not report the concerns to the Director until a second email was sent to the management team regarding the same concerns three weeks later.

By not reporting the allegations of improper care to the Director immediately, the Director was unable to respond in a timely manner.

Sources: Critical Incident (CI) #2942-000011-22, home's concerns follow up form, and an interview with the Director of Resident Care. [722374]

COMPLIANCE ORDER CO #001 Emergency Plans

NC #02 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 90 (1) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with s. 90 (1) (b) of FLTCA, 2021.

Further, the licensee shall:

1. Review and revise the resident's emergency evacuation plan and procedure taking into consideration the resident's condition, location in the home, and equipment available. The plan must be based on best practice and be documented including the date, content revised, any changes to the plan as a result of

the review and participants in the review.
2. An onsite trial of the evacuation plan for the resident must be conducted by the home to evaluate its effectiveness. The date and who participated in the trial must be documented as well as a record of any changes made based on the outcome of the trial.
3. All staff must be educated on the revised evacuation plan for the resident. A record of the education must be kept in the home and include the date the education was completed, attendees and the content of the education.
4. The resident's emergency evacuation plan must be available for review by all staff and kept in a location that is accessible to all staff and emergency personnel.

Grounds
The licensee failed to ensure there were emergency plans in place for the home, which included procedures for evacuating and relocating a resident in case of an emergency.

Rationale and Summary
A resident's evacuation plan was last updated on a specified date. Over the next two years, the resident had a significant change in condition.

According to the Administrator, the change in the resident's condition since the evacuation plan was reviewed, may prevent them from being safely evacuated due to building restrictions.

A Fire Prevention team attended the home to provide high level recommendations in relation to the resident's evacuation plan. A member of the fire prevention unit stated that it was up to the home to develop the specifics of their evacuation plan and procedure and to ensure that specified areas of the home were assessed by subject matter experts.

The home has failed to revise or trial an emergency plan for a resident since the change in their condition. In the absence of a viable evacuation plan for the resident, there is potential risk to the resident's safety in the event of an emergency.

Sources: Observation of a resident, a resident's clinical records, interviews with the Administrator, Director of Resident Care, a member of the fire prevention unit and working document-evacuation plan for a resident. [706119]

This order must be complied with by: January 25, 2023

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.