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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: March 28, 2023
Original Report Issue Date: March 17, 2023
Inspection Number: 2023-1426-0003 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Holland Christian Homes Inc.
Long Term Care Home and City: Grace Manor, Brampton

Amended By	**Inspector who Amended Digital Signature**
Romela Villaspir (653)	Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.03.29 09:35:28 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been amended to reflect that Non-Compliances (NCs) #05, and #10 have been rescinded. The Complaint and CIS inspection #2023-1426-0003 was completed on February 22-24, 27-28, March 1-3, 6, and off-site on March 7, 2023.

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Licensee: Holland Christian Homes Inc.	
Long Term Care Home and City: Grace Manor, Brampton	
Lead Inspector Romela Villaspir (653)	**Additional Inspector(s)** Daniela Lupu (758)
Amended By Romela Villaspir (653)	**Inspector who Amended Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.03.29 09:35:52 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been amended to reflect that NCs #05, and #10 have been rescinded. The Complaint and CIS inspection #2023-1426-0003 was completed on February 22-24, 27-28, March 1-3, 6, and off-site on March 7, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 22-24, 27-28, March 1-3, 6, 2023, and off-site on March 7, 2023.

The following intakes were completed in this complaint inspection:

- Intake #00018148 was related to personal hygiene, skin and wound care, infections, housekeeping and maintenance, medication, and nutrition and hydration.

- Intakes #00019223, #00019316, #00019625 were related to oral care, lost personal item, appropriate clothing, skin and wound care, infection, plan of care, and nutrition and hydration.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00001926 was related to an allegation of abuse.
- Intake #00013108 was related to an injury from unknown cause.
- Intake #00014282 was related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: ORAL CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (b)

The licensee has failed to ensure that a resident received oral care that included physical assistance to help them brush their own teeth.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint related to a resident's poor oral care.

The resident's care plan directed the staff to provide assistance with oral care, and under the Point of Care (POC) task for mouth care, staff were directed to provide mouth care after each meal.

Two Personal Support Workers (PSWs) indicated they provided oral care to the resident as part of their care, but they did not provide oral care after meal service.

By not providing oral care to the resident after meal service, there was a risk for the resident to have gum and dental health problems.

Sources: Resident's clinical health records; Interviews with PSWs, the Director of Resident Care (DRC), and other staff. [653]

WRITTEN NOTIFICATION: LAUNDRY SERVICE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 89 (1) (a) (iv)

The licensee has failed to ensure that procedures were implemented to report and locate a resident's lost personal item.

Rationale and Summary

The home's Personal Care Items policy indicated that if personal care items were lost, the nursing staff will search the resident's room as well as the unit. They will immediately notify laundry staff of a potential missing item. Upon confirmation that the items were missing, the Power of Attorney (POA) will be notified. If the items cannot be located, Holland Christian Homes (HCH) Manor Administration will review the next steps with the family.

In February 2021, a resident had a zoom call and the family asked about their personal item. A Former Activation Aide (FAA) searched every drawer in the resident's room but could not find it. The FAA notified the other staff that the resident's personal item could not be found. The HCH Manor Administration did not review the next steps with family as they were not informed by staff when the item could not be located.

The HCH Manor Administration was only informed about the missing personal item by the resident's family during the annual care conference that was held a year and three months after the item was noted missing by staff.

By not informing the HCH Manor Administration about the missing personal item when staff could not locate it, there was a delay in addressing the concern by the management team.

Sources: Resident's clinical health records, the home's Personal Care Items policy #NPC-C-02, original date: 07/19/2018, Family/Residents/Staff concern or feedback form; Interviews with staff, and the DRC. [653]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating signs of infection for a resident, were monitored in accordance with the Ministry's COVID-19 Guidance for Long-Term Care Homes (LTCHs).

Rationale and Summary

The COVID-19 Guidance Document for LTCHs in Ontario, effective June 11, 2022, and updated on December 23, 2022, required homes to abide by the requirements set out in the COVID-19 Guidance LTCHs, Retirement Homes (RHs), and Other Congregate Living Settings for Public Health Units (PHUs) effective June 27, 2022, and updated on October 6, 2022, and January 18, 2023.

The COVID-19 Guidance LTCHs, RHs, and Other Congregate Living Settings for PHUs, documented that during a suspect or confirmed outbreak, homes should continue to conduct enhanced symptom assessment minimum twice daily of all residents to facilitate early identification and management of ill residents.

The home's Isolation Outbreak Management Plan, revised on June 23, 2022, documented that the home would follow the current directives for additional measures in case of positive resident cases.

A COVID-19 outbreak was declared at the home.

A resident was placed on additional precautions due to signs and symptoms of respiratory illness, and later tested positive for an infection. The resident was not consistently monitored for symptoms, and their vital signs were not checked twice daily during the isolation period, and until the symptoms were resolved.

The resident's condition deteriorated, and they were transferred to the hospital.

The DRC said if the resident had new symptoms or if the symptoms worsened, the NP or the physician

should have been informed for further assessment and treatment.

Not following the directions related to enhanced symptom monitoring during the COVID-19 outbreak, might have contributed to the late detection of symptoms associated with the deterioration in the resident's medical condition.

Sources: Critical Incident (CI) report, resident's progress notes, electronic Medication Administration Record (eMAR), weight and vitals summary, hospital records, the home's isolation outbreak management plan (June 2022, and February 2023), Minister's Directive: COVID-19 response measures for LTCHs (August 30, 2022), COVID-19 Guidance Document for LTCHs in Ontario (December 23, 2022), the COVID-19 Guidance LTCHs, RHs, and Other Congregate Living Settings for PHUs (June 27, 2022) and (October 6, 2022); Interviews with the home's IPAC Lead, the DRC, RPNs, and other staff. [758]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the home's policy on Physician/ Nurse Practitioner Orders, was complied with.

Rationale and Summary

O. Reg. 246/22, s. 123 (2) requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

O. Reg. 246/22, s. 123 (3) (a) requires the written policies and protocols to be implemented.

The home's Physician/ Nurse Practitioner Orders policy indicated that the nurse is responsible to transcribe the order to the electronic Treatment Administration Record (eTAR).

The NP ordered a new treatment for a resident's wound. A review of the order audit report and the resident's eTARs, showed that the NP's order was not transcribed properly, as it was missing the location of the wound for the scheduled dressing change.

There was risk of staff not being aware of the wound location.

Sources: Resident's clinical health records, CI report, Physician/ Nurse Practitioner Orders policy #PM06 last revised on June 24, 2021; Interviews with the ADRC, DRC, and other staff. [653]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A) A resident had a physician's order for scheduled and as needed (PRN) medication for a maximum amount, from all sources.

On a day in December 2022, the amount of medication the resident received, exceeded their maximum prescribed dose.

A RPN said they were not aware of the maximum dose of the medication as specified in the physician's order.

The DRC said staff should have checked the order for the maximum amount of medication and inform the next shift of the PRN administration.

Not following the directions for use as specified by the prescriber resulted in the administration of an incorrect amount of the prescribed medication.

Sources: Resident's progress notes, physician's orders, eMAR; Interviews with a RPN, DRC, and the physician.

B) The resident had a physician's order for a treatment to be administered PRN.

On a day in December 2022, the PRN treatment was not administered to the resident.

The RPN said they did not administer the treatment as prescribed, as they were advised by the RN to wait for the resident's vital sign to reach a certain level.

The DRC said staff should have administered the PRN treatment as prescribed, considering the resident's medical condition.

Not administering the treatment as prescribed by the physician resulted in lack of appropriate measures taken when the resident's vital sign was outside of the normal range.

Sources: Resident's progress notes, physician's orders, eMAR; Interviews with a RPN, DRC, and the physician. [758]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that a resident's repositioning intervention was documented.

Rationale and Summary

The resident was at risk for skin breakdown and their plan of care required the staff to reposition the resident at certain intervals.

A review of the resident's clinical health records showed no documentation of the repositioning intervention for 36 days.

The home's DRC said that the resident's intervention related to repositioning should have been documented as specified in their plan of care.

Failing to ensure that the staff documented when they repositioned the resident, increased the risk that the effectiveness of this intervention could not be evaluated.

Sources: Resident's clinical health records; Interviews with the DRC, RPN, PSW, and other staff. [758]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #08 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's plan of care for wound treatment and personal hygiene, was followed as specified in the plan.

Rationale and Summary

A) The resident had a wound, and their care plan documented that registered staff would complete treatments as specified in the eTAR until healed. The wound treatment was to be completed as scheduled in the eTAR.

A review of the eTAR showed that wound treatments were not completed as scheduled on three different days, and there was no follow up to indicate the treatment was completed on the following shifts.

The DRC said if the wound treatment was not completed as scheduled, it should be completed within 24 hours.

Gaps in completing the treatment for the resident's wound at the frequency specified in their plan of care, increased the risk that the wound healing could have been delayed or the wound could have deteriorated.

Sources: Resident's progress notes, care plan, eTAR; Interviews with RPNs, and the DRC.

B) The resident's plan of care required the staff to complete a care task using a product.

A review of the eTAR showed that the care task was not completed as specified in the plan of care on three different days.

A PSW said they were not aware of the product used for the care task, and they did not use it for the resident.

The DRC said if the eTAR included the use of the product for the care task, the registered staff should have ensured the care task was provided as indicated in the plan of care.

Not providing the care as specified in the resident's plan of care increased the risk associated with poor hygiene.

Sources: Resident's progress notes, care plan, eTAR; Interviews with RPNs and the DRC. [758]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #09 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The licensee has failed to comply with the system to monitor and evaluate a resident's food and fluid intake.

Rationale and Summary

According to O. Reg. 246/22, s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

O. Reg. 246/22, s. 74 (2) (d) requires the hydration program to include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, and it must be complied with.

The home's policy titled Resident Food and Fluid Monitoring, last revised on July 19, 2021, documented that PSWs would inform the Charge Nurse if a resident's food intake is less than 50 per cent for three days or if the resident's fluid intake varies from their usual pattern or if signs of dehydration were observed.

A resident was at nutritional risk, and required a daily minimum fluid intake.

The resident had a respiratory infection, and the home's Registered Dietitian (RD) ordered an additional nourishment for the resident. Staff were directed to refer to the RD if the resident's appetite decreased.

Prior to the respiratory infection, the resident's food intake was between 75 to 100 per cent at most meals and nourishments, and their fluid intake exceeded the daily minimum requirement on most days.

When the resident had the respiratory infection, they had poor appetite and their food and fluid intake at meals decreased. The resident did not meet their daily minimum fluid requirement for 13 days. Additionally, the resident refused their nourishment or did not have any nourishment on some days.

The resident also experienced weight loss.

No referrals were sent to the RD, and no notification to the physician or the NP were made in relation to the resident's low oral intake.

The resident's condition deteriorated, and they were transferred to the hospital.

The DRC said that appropriate actions should have been implemented to address the resident's low food and fluid intake.

By not monitoring and evaluating the resident's food and fluid intake, appropriate actions could not be implemented to address the resident's low oral intake, which contributed to the overall deterioration of the resident's condition.

Sources: Resident's clinical health records, hospital records, the home's policy on food and fluid intake monitoring; Interviews with the PSWs, RPNs, RD, the physician, and the DRC. [758]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #11 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, when they exhibited altered skin integrity.

Rationale and Summary

The home submitted a CI report to the MLTC related to the improper/ incompetent treatment of a resident.

A PSW reported to a RPN that the resident had a skin impairment. Upon assessment, an injury was noted. The resident's skin impairment was assessed by the NP, and the NP documented the treatment plan in the progress notes. The resident's eTAR was not immediately updated, and the treatment plan was added two days after the skin impairment was assessed by the NP.

By not receiving immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, there was risk for a delay in wound healing.

Sources: Resident's clinical health records, CI report, Skin and Wound Care – Treatments policy #NUR-01-101 last revised on February 22, 2021; Interviews with the RPNs, the NP, ADRC, DRC, and other staff. [653]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #12 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident had three areas of altered skin integrity, and all three areas were not reassessed at least weekly by a member of the registered nursing staff, for a certain period.

The DRC said that wound assessments should be completed weekly and include all the information listed in the assessments as per the home's skin and wound protocol.

Gaps in completion of the weekly skin assessments increased the risk that appropriate interventions were not implemented in a timely manner if the wounds started to deteriorate.

Sources: Resident's progress notes, skin and wound evaluation assessments, wound pictures, eTAR; Interviews with the RPNs and DRC. [758]