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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 25, 2024	
Inspection Number: 2023-1426-0008	
Inspection Type: Critical Incident	
Licensee: Holland Christian Homes Inc.	
Long Term Care Home and City: Grace Manor, Brampton	
Lead Inspector Janet Groux (606)	**Inspector Digital Signature** Janet Groux Digitally signed by Janet Groux Date: 2024.01.25 10:22:29 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates:
December 20, and 21, 2023, and January 2-5, 2024.
The inspection occurred offsite on the following date:
December 22, 2023.

The following Critical Incident System (CIS) intakes were inspected:
• Intakes #00089909 and #00091289 regarding the home's Falls Prevention and Management Program.
• Intake #00101405 regarding the home's Outbreak Management Program.

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

Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to a resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's falls prevention and management plan of care was provided to the resident as specified in the plan.

Rationale and Summary:

A resident was at high risk for falls.

The resident was assessed by the Physiotherapist (PT) and advised that a specified falls intervention equipment be discontinued. The PT said that having the specified falls intervention equipment would be a safety risk as it could be a tripping hazard for the resident.

The resident's falls prevention and management care plan was revised, and the use of the specified falls intervention equipment was discontinued. This was also communicated to staff during the shift reports.

Two Personal Support Workers (PSW) and a Registered Staff said that the specified falls intervention was in place when the resident had a fall a few days after.

Failure to ensure the resident's falls prevention care plan was followed may have contributed to the resident's fall and caused the resident to sustain an injury.

Sources: a CIS report, a resident's clinical records, and interviews with staff. [606]