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: May 7, 2024
Inspection Number: 2024-1426-0001
Inspection Type: Complaint Critical Incident
Licensee: Holland Christian Homes Inc.
Long Term Care Home and City: Grace Manor, Brampton

Lead Inspector	**Inspector Digital Signature**
Gurvarinder Brar (000687)	Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2024.05.07 14:23:56 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22- 25, 2024

The following intake(s) were inspected:

- Intake: #00112269, related to Abuse/ Improper care
- Intake: #00113863, Anonymous complaint related to unexpected death of resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Duty to protect

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. Ensure weekly audits are completed for four weeks on home area- 1 south to ensure staff are completing post fall assessments as set out in the licensee's Fall Prevention and Management Policy.
2. The audits should include:
    1. The date and time of the fall;
    2. Whether the post fall assessments were completed, name of the assessments, location and time completed, and name of the person who completed them;
    3. The date and time the POA and MD were notified;
    4. The name of person who completed the above audit; and
    5. A description of follow up actions taken when there was a gap identified from the audit.

Grounds
The licensee failed to ensure that resident was protected from neglect by a Registered Nurse.

The Ontario Regulation 246/22 defines neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rational and Summary
The Ministry of Long-Term Care received a complaint stating that resident was not examined after having a fall.

A Personal Support Worker (PSW) reported the fall to the Registered Nurse (RN).

The resident's clinical record showed no mention of the fall incident, nor any post fall assessments completed for the resident. There was no documentation that family and the physician was contacted in relation to the fall incident.

The DOC was not aware that the resident fell until LTCH Inspector #000687 brought it to their attention during the inspection.

The Director of Care (DOC) stated that the RN should have assessed resident and notified the POA and the physician of the fall.

The inaction by registered staff of not assessing the resident post fall, not notifying the POA and the physician and not providing treatment based on that assessment, may have contributed to the resident's decline.

Sources
Resident's clinical record. Interviews with Personal Support Worker, Registered Nurses, Director of Care and the physician. [000687]

This order must be complied with by June 18, 2024

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.