

**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

**Public Report**

**Report Issue Date:** January 31, 2025

**Inspection Number:** 2025-1426-0001

**Inspection Type:**

Complaint  
Critical Incident

**Licensee:** Holland Christian Homes Inc.

**Long Term Care Home and City:** Grace Manor, Brampton

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 15 -17, 20-24, 28-30, 2025.

The following intake(s) were inspected:

- Intake: #00134354; Intake: #00134925 – related to fall prevention and management.
- Intake: #00135891 – Complainant related to care of a resident and prevention of abuse and neglect.
- Intake: #00135905– Related to prevention of abuse and neglect.

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

Resident Care and Support Services  
Infection Prevention and Control  
Safe and Secure Home  
Prevention of Abuse and Neglect

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Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: General requirements

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

**Non-compliance with: O. Reg. 246/22, s. 34 (2)**

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under a program were documented. A Personal Support Worker (PSW) informed Registered Nurse that a resident's hand was swollen. The PSW stated that the RN checked the resident at that time. The RN did not document their assessment.

**Sources:** The Home's Internal Investigation Notes, The Documentation Guidelines policy, interview with staff.

### WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,  
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

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(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment for a new area of altered skin integrity by an authorized person using a clinically appropriate instrument that is specifically designed for skin and wound assessment. A Personal Support Worker (PSW) reported to Registered Nurse (RN) that a resident had a new altered skin integrity on a specified area. The RN did not assess the altered skin integrity.

**Sources:** The Home's internal investigation interview notes, record review, interview with staff and the Wound Care Treatments policy.

## **COMPLIANCE ORDER CO #001 Transferring and positioning techniques**

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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.

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

The Licensee shall ensure:

1. Review the home's procedure to ensure it directs staff to use the appropriate equipment, including a personal assistive device.

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2. Provide training on safe transporting of residents and proper use of personal assistive devices to all employees on a specified home area.
3. There must be a record of this education kept in the home which includes all materials reviewed, the date the education was provided and completed, and signed by employees responsible for bathing and showering that attended the education as well as the individual providing the education.
4. Conduct, at minimum, an audit of all residents using the assistive device air on a specified resident home area to ensure staff are utilizing the personal assistive devices correctly. Audits are to be discrete and completed for a period of one month. Audits must include a balance of days and evenings, and specific to baths and showers and different staff when able.

**Grounds**

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

A resident was deemed at high risk of falling. A resident sustained an injury after a fall. The physiotherapist stated that the resident had multiple diagnoses and that the staff member should have used a personal assistive device before escorting the resident. There was an actual impact on the resident when PSW failed to use safe transferring techniques, such as using a personal assistive device for safety while transferring the resident.

Sources: Clinical records i.e., progress notes, fall risk assessment, risk management, plan of care for resident, E mails from DOC, observations, interview with staff members.

**This order must be complied with by** February 24, 2025

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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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

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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, 9<sup>th</sup> Floor

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Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).