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

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Original Public Report

Report Issue Date: December 21, 2022	
Inspection Number: 2022-1573-0001	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of Peel	
Long Term Care Home and City: Peel Manor, Brampton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2022.12.28 13:32:07 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5-9, and 13-14, 2022

The following intake(s) were inspected:
- Log #00002552, and Log #00005507, related to abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that two residents were protected from abuse by a Personal Support Worker (PSW).

Rationale and Summary

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A. A resident required assistance from one staff member with their care.

On one occasion, the resident informed a PSW and the Director of Care (DOC) that a different PSW was inappropriate with them during care. The resident told the PSW to stop providing care, however, the PSW continued to assist them.

The resident also said that on other occasions, the same PSW was inappropriate with them during care.

The resident said they felt offended and disrespected with how the PSW treated them, but they were afraid to report it. They requested the DOC and a Registered Nurse have that PSW removed from their care.

The PSW's interaction with the resident caused them emotional distress and fear.

Sources: a critical incident (CI) report, a resident's clinical records, the home's investigative notes, and interviews with a resident, an RN, the DOC and other staff. [758]

B. A resident needed assistance from one staff member with their continence care.

On one occasion, the resident asked a PSW to assist them with their continence care. When the PSW provided the care, they appeared upset with the resident and their approach was inappropriate.

The resident said they felt disrespected, demeaned, and helpless because the way the PSW treated them.

The PSW's interaction with the resident during care triggered the resident's emotional distress.

Sources: a CI report, a resident's clinical records, the home's investigative notes, and interviews with a resident, two RNs, the home's Social Worker and the Director of Care. [758]

WRITTEN NOTIFICATION: Policy to promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure their policy related to prevention of abuse and neglect was complied with for two residents.

Rationale and Summary

The home's policy titled Prevention, Reporting and Elimination of Abuse/Neglect, directed the RN/RPN to document any occurrences of actual or suspected abuse and/or neglect in the resident's electronic health record. The DOC/Supervisor of Care and/or RPN would ensure that a signed and dated statement indicating all information witnessed or acquired after verbally reporting the incident was obtained and the appropriate risk management was completed in the Point Click Care (PCC). The policy also documented that meetings with all other employees and individuals who might have had knowledge of the incident under the investigation were completed.

A. A resident reported an incident of abuse by a PSW to a different PSW. The resident also reported the incident to an RN later on the same day.

The resident's electronic health care records did not include any documentation of the occurrence of abuse. Additionally, the home's incident investigative notes did not include a dated and signed written statement from the PSW who received the report.

The DOC said when an incident of abuse was reported to an RN and/or RPN, it should have been documented in the resident's health record.

By not documenting the occurrences of abuse in the resident's health records, the registered staff were not made aware of the incident, and actions to minimize the risk of recurrence could not be implemented.

By not taking a written signed and dated statement of the person who had the knowledge of the incident, accurate incident information could have been missed.

Sources: a resident's electronic health records, the home's prevention of abuse and neglect policy, the home's investigative records, and interviews with an RN, and the DOC. [758]

B. A resident informed the home's Social Worker (SW) of an incident that occurred four days earlier,

when a PSW was disrespectful with them during care. The SW immediately informed one of the home's Supervisor of Care (SOC) and the DOC of the alleged abuse.

The resident's electronic health care records in PCC did not include any documentation of the occurrence of abuse. Additionally, the home's investigative notes did not include any interviews with the two RNs who had knowledge of the resident's concerns related to their care on the day of the incident.

By not documenting the occurrences of abuse in the resident's health records, the registered staff were not aware of the incident and could not monitor the PSW's interaction with the resident.

By not interviewing all the individuals that might have had knowledge of the incident, essential information for the investigation could have been missed.

Sources: a resident's electronic health records, the home's prevention of abuse and neglect policy, the home's investigative records, and interviews with two RNs, and the DOC. [758]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

A. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals.

The home's Hand Hygiene policy, documented that staff should offer residents hand hygiene prior to eating.

On one occasion, during the lunch meal service on one of the resident home areas, staff did not encourage or assist six residents with hand hygiene prior to eating.

The home's IPAC Lead said residents should be encouraged with hand hygiene upon going into the dining room before their meals.

Gaps in residents' hand hygiene practices before eating, increased the risk of possible transmission of infectious microorganisms.

Sources: observation of a meal service, IPAC Standard (April 2022), the home's hand hygiene policy, and interviews with a resident, the home's IPAC Lead and other staff.

B. The IPAC Standard for LTCHs, dated April 2022, section 9.1 indicates that Routine Practices should be followed in the IPAC program and should include proper use of Personal Protective Equipment (PPE), such as appropriate selection, application, removal, and disposal.

The home's training package for staff performing Rapid Antigen Testing (RAT) indicated that staff would follow the Ontario Health COVID-19 RAT onboarding guide when testing on site.

Ontario Health COVID-19 Rapid Antigen Testing Onboarding guide, version 8, July 13, 2022, documented that medical mask, eye protection, gown and gloves were required for all individuals performing Rapid Antigen Tests on site.

On one occasion, a staff member did not wear eye protection when they collected nasal swabs from two visitors.

The home's IPAC Lead and a different staff member said eye protection in addition to mask, gown and gloves should be worn when collecting nasal swabs for RAT.

By staff not wearing the appropriate PPE there was a potential risk of exposure and spreading infectious microorganisms amongst residents, staff, and visitors.

Sources: observation of RAT practices, the home's PPE policy and interviews with the IPAC Lead, and a staff member. [758]