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: March 07, 2024

Inspection Number: 2024-1573-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Peel Manor, Brampton

Lead Inspector	**Inspector Digital Signature**
Gurvarinder Brar (000687)	Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2024.04.02 13:48:03 -04'00'

Additional Inspector(s)
Janet Groux (606)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 21-23, 26-29, 2024, and March 1, 2024

The following intake(s) were inspected:

- Intake: #00108567 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure a resident received personal care by the method of their choice.

Rationale and Summary:
A resident's care did not include a bath of their choice.

A Personal Support Worker (PSW) acknowledged that the resident did not received a bath as per their preference.

Failure to provide the resident a bath of their preferred method could potentially put

the resident at risk of infection.

Sources: Observations of resident's care, review of clinical records and interviews with staff. [606]

WRITTEN NOTIFICATION: Plans of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan.

Rationale and Summary:
A resident said they were dissatisfied with the care they received.

The PSW said they were not familiar with resident's plan of care and did not perform the tasks as the resident wanted.

The Supervisor of Care acknowledged that the PSW did not follow the resident's care plan for personal care.

Failure to provide the resident their care according to their plan of care caused the resident to be emotionally affected.

Sources: Resident care plan, progress notes, the home's investigation records, and interview with resident and staff. (606)