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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Public Report

Report Issue Date: February 27, 2025

Inspection Number: 2025-1573-0001

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Peel Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 13-14, 18-21, 25-27, 2025.

The following Complaint intake was inspected:

- Intake: #00137748 related to medication management, falls prevention and management, continence care, recreation and social activities, and resident care and support services.

The following Critical Incidents (CIs) were inspected:

- Intake: #00132116 related to abuse.
- Intake: #00138474 related to an outbreak.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan, when an intervention was not in place at the time of the Inspector's observation. Thirty-five minutes following the observation, a Personal Support Worker (PSW) implemented the intervention.

Sources: Resident's written plan of care; Inspector's observation; Interview with a PSW.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's Substitute Decision-Maker (SDM), was given an opportunity to participate fully in the implementation of the resident's plan of care, when they were not informed about the resident refusing a care intervention.

Sources: Resident's clinical health records; Interviews with Registered Practical Nurses (RPNs), PSWs, and the Supervisor of Care (SOC).

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to protect a resident from abuse by a PSW.

A PSW made inappropriate verbal remarks to a resident during care. The resident was upset and felt degraded by the incident.

Sources: Critical Incident (CI) report, resident's clinical health records, the home's internal investigation notes, letter of discipline; Interviews with a PSW and the SOC.

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #004 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 the recreation and social activities program, including interventions and their responses to interventions, were documented.

A review of the resident's POC records showed missing documentation for recreation in January 2025.

Sources: Activation Calendar January 2025, resident's written plan of care; Interviews with the Activation Staff and Supervisor of Resident Support Services.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed when Public Health declared a confirmed gastroenteritis outbreak in the home.

Sources: CI report; Interview with the Infection Prevention and Control (IPAC) Lead.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The licensee failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

A resident was administered medications that were not prescribed by their attending physician.

Sources: Resident's clinical health records, medication incident report; Interviews with the Registered Nurses.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

An attending physician ordered medications for a resident, and the medications were not administered to them.

Sources: Resident's clinical health records; Interviews with the RNs.

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Sources: The home's record of medication incidents, CareRx Medication Incident Reporting Policy #9.2, resident's clinical health records; Interviews with the SOC and other staff.

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The licensee failed to ensure that the medication incident involving a resident was reported to the resident's SDM, the Medical Director, and the pharmacy service provider.

Sources: The home's record of medication incidents, CareRx Medication Incident Reporting Policy #9.2, resident's clinical health records; Interviews with the SOC and other staff.