Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 29, 2017	2017_561583_0013	004026-17, 004473-17	Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

Long-Term Care Home/Foyer de soins de longue durée

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 27 and 28, 2017.

Follow Up Inspection was completed for log #004026-17 and log #004473-17.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Supervisors of Care, Maintenance Staff, Resident Assessment Indicator (RAI) Co-ordinator, Registered Nurse (RN), Personal Support Worker (PSW) and residents.

During the course of the inspection, the inspector also observed the provision of care and services and reviewed documents including but not limited to, clinical records, maintenance reports, dietary reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #002	2017_546585_0001	583
O.Reg 79/10 s. 69.	CO #001	2017_546585_0001	583

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to apply the physical device in accordance with the manufacture's instructions.

During an observation in June 2017, resident #102 was observed by Long Term Care (LTC) Inspector #583 wearing a device that did not fitted properly. Registered Nursing staff #001 and PSW staff #002 observed the resident with LTC Inspector #583 confirmed this. The resident was not able to remove the device at the time of the observation. The staff shared that the purpose of the device was to prevent incidents that could cause injury.

In an interview with Registered Nursing staff #001, Supervisor of Care #003 on June 27 and with Supervisor of Care #004 on June 28, 2017, it was confirmed that resident #102's device was not applied as per the manufactures instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure physical devices are applied in accordance with the manufacture's instructions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs of that resident.

During an observation in June 2017, resident #102 was observed by Long Term Care (LTC) Inspector #583 wearing a device that was not fitted properly. Registered Nursing staff #001 and PSW staff #002 observed the resident with LTC Inspector #583 confirmed this. The resident was not able to release the device at the time of the observation. The staff shared that the purpose of the device was to prevent the resident from falling, as the resident had a history of frequent falls.

The assessment completed in 2017, identified what the device was assessed to be. A review of resident #102's care plan identified the device had a different purpose. In an interview with Supervisor of Care #003 and #004 it was confirmed that resident #102's plan of care was not based on the assessment completed in 2017. [s. 6. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Resident #102 was assessed to required a physical device. It was identified that staff were not documenting that resident #102 was released from the physical device and repositioned at least once every two hours. In an interview with Supervisor of Care #003 it was confirmed that actions taken with respect to a resident under a program, including resident #102's interventions were not documented. It was shared that a task had not been created for staff to complete this documentation in Point of Care. [s. 30. (2)]

Issued on this 29th day of June, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.