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: November 3, 2023
Inspection Number: 2023-1611-0004
Inspection Type: Critical Incident
Licensee: The Regional Municipality of Peel
Long Term Care Home and City: Tall Pines Long Term Care Centre, Brampton

Lead Inspector	**Inspector Digital Signature**
Yami Salam (000688)	Yami Salam Digitally signed by Yami Salam Date: 2023.11.03 16:04:14 -04'00'

Additional Inspector(s)
Diane Schilling (000736)
Kristen Owen (741123) was present during inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25-27, 30-31, 2023 and November 1, 2023

The following intake(s) were inspected:
- Intake: #00089401 - Related to fall of a resident resulting in injury
- Intake: #00096092 - Related to fall of a resident resulting in injury

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

Infection Prevention and Control
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)

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

Rationale and Summary:
The plan of care for a resident stated that the resident was to use a specific communication device.

The resident was observed not to have access to the specific communication device.

A staff member stated that the resident should have access to a communication device and provided the resident a new one. Later that day, the resident was observed to have access to communication device as indicated in the plan of care.

Sources: Observations and clinical record review of the resident, interviews with staff. [000736]

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) (a) (ii)

The licensee has failed to ensure that a skin assessment was completed for a resident, who was at risk of altered skin integrity when they returned from hospital.

Rationale and Summary:
A resident with a history of altered skin integrity returned from a hospital admission.

A head-to-toe assessment was not completed upon the resident's readmission to the home.

Failure to complete a skin assessment for the resident upon their return from hospital may have resulted in skin integrity issues not being addressed and treated.

Sources: Review of resident's clinical records, interview with staff. [000736]