Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, ~~Sep 15, 16, 18, 19, 20, 21, Oct 12, 16, 17, 18, 2011~~ Aug 30, Sep 9, 2011	2011_071159_0014	Critical Incident

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Nurse Supervisor, Food Service Manager, Dietary staff, Registered Nursing staff, Personal Support Service Workers (PSWs), Activation Supervisor, Activation aide and Residents in regards inspection H-001524-11

During the course of the inspection, the inspector(s) Reviewed resident health record, and Volunteer Service program and policy procedure manual, interviewed Registered Practical Nurse, Activation Supervisor, PSWs, and spoke with the residents.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to an identified resident as specified in the plan. LTCHA 2007, S,O. 2007, c. 8, s.6 (7)
On August 23, 2011, interview conducted with Registered Practical Nurse it was indicated that identified resident was taken down to church service by a volunteer and then was taken outside and left unattended in front of the building. Resident was found by staff wandering the adjacent street over three hours later, however, resident's plan of care clearly indicated the resident is at high risk for elopement due to cognitive deficit. Allow resident to wander on unit, staff to supervise closely and make regular compliance round. Resident require close supervision when attending communal activities. Staff did not ensure the care set out in the plan of care was provided to resident in relation to elopement risk.

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 with ensuring that the care set out in the plan of care is provided to resident as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 94. Volunteer program

Specifically failed to comply with the following subsections:

s. 94. (2) Every licensee of a long-term care home shall ensure that a staff member monitors or directs a volunteer whenever it is necessary to ensure the safety of a resident. O. Reg. 79/10, s. 94 (2).

Findings/Faits saillants :

1. Licensee did not ensure that a staff member monitors or directs a volunteer whenever it is necessary to ensure safety of a resident. O.Reg.79/10, s. 94 (2)
It was reported that a Critical Incident occurred related to an identified resident left unattended by a volunteer in front of the building and was found wandering the adjacent streets.
On August 23, 2011, interview with the Registered Practical Nurse confirmed that the volunteers are recruited and supervised by Recreational Department, and there are no systems in place for monitoring and supervising volunteers by nursing.
On September 2, 2011, interview with the Activation Supervisor, confirmed that the volunteer involved in the incident was not provided direction and supervision related to safety and assistance for the benefit of residents. There is a no coordination between nursing and activation department with regards to monitoring and supervising volunteers. The activation supervisor reported that the volunteer training program is not home specific, nor at the operational level. The Region of Peel is in the process of reviewing the volunteer services including orientation and training program for volunteers.

Issued on this 26th day of October, 2011

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