Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2020	2020_826606_0016	000544-20, 009234-20, 013291-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor 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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 4-7, and 10, 2020.

The following Critical Incident (CI) Intakes were inspected:
Log #009234-20 regarding a resident fall resulting in a serious injury and Log #013291-20 regarding an allegation of staff to resident abuse.

The following Follow Up Intake was inspected:
Log #000544-20, Follow Up to Order (CO) #001 from inspection #2019_821640_0031/010869-19, 016574-19, 017481-19, 021063-19, 021415-19, 022199-19 regarding r. 51 (2) with a Compliance Due Date (CDD) of March 20, 2020.

During the course of the inspection, the inspector(s) spoke with the Supervisors of Care (SOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and residents.

The inspector also toured a resident home area, observed resident staff interaction, reviewed relevant residents' clinical records, Home's investigations, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 51. (2)	CO #001	2019_821640_0031	606

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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident (CI) submitted to the Ministry of Long Term Care (MLTC) reported an allegation of resident abuse.

The Home's resident abuse policy directed staff to initiate the following:
- that any person who has witnessed or has reasonable grounds to suspect abuse of a resident to immediately report the incident to the centre's administration/designate and the Director of the MLTC; and
-if the alleged abuser/neglector is a staff member, the staff member will be immediately placed on leave of absence (LOA).

Resident #012's clinical records said the resident told their Substitute Decision Maker (SDM) they were abused by a staff member during morning care. Resident #012's SDM notified Registered Nurse (RN) #104 and informed them of the abuse allegation by the resident.

Personal Support Worker (PSW) #101 said resident #012 accused them of abuse earlier during the shift but did not report to RN #104 about the resident's abuse allegation until RN #104 approached them at the end of the shift.

RN #104 said resident #012's SDM notified them that the resident accused a staff member of abuse. They said they notified their supervisor of the incident via email but did not call the Director of the MLTC to report the abuse allegation as directed in the Home's policy.

Supervisor of Care (SOC) #103 stated they became aware of resident #012's abuse allegation later on in the evening and called the Home to follow up on the incident. They said PSW #104, who was still in the Home working on another unit, was sent home and placed on a LOA and they directed the Charge Nurse to notify the Director of the MLTC about the incident. SOC #103 acknowledged the staff did not follow the Home's policy.

The Licensee failed to comply with the Home's abuse policy for resident #012.

Issued on this 26th day of August, 2020

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

Original report signed by the inspector.