

**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**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2021	2021_781729_0007	021989-20, 023894- 20, 000720-21	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

KIM BYBERG (729), AMANDA COULTER (694)

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): February 8, 9, 2021.

The following intakes were completed within the Critical Incident inspection:

-Log #021989-20, related to the transfer of a resident to the hospital with a significant change in condition,

-Log #023894-20, related to the transfer of a resident to the hospital with a significant change in condition,

-Log #000720-21, related to COVID-19 outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control Lead, Registered Nurse (RN), Personal Support Workers (PSW), and Residents.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the homes' infection prevention and control program, specifically related to appropriate usage of personal protective equipment (PPE) and the disinfection of equipment.

A) A Resident required the implementation of additional precautions as specified by contact precautions signage that was posted outside their room. Contact precautions signage stated staff were to wash their hands, wear gloves and a gown for all activities in the room, and to remove gown and gloves before leaving the room.

A staff member was observed in the residents room without a gown or gloves and was completing hand and nail care for the resident.

B) A resident was in isolation and required staff to implement droplet contact precautions when entering their room. A staff member was observed to enter the residents room with a computer tablet, complete documentation on the tablet, leave the residents room, place the tablet on the PPE cart that was outside the room, doff PPE and continue to use the tablet without disinfecting it after use and before entering the next resident room.

PIDAC: Routine Practices and Additional Precautions in All Health Care Settings | November, 2012, stated that chart (paper or mobile electronic) should not be taken into the resident environment.

Gaps in the implementation of the home's infection prevention and control program had the potential to increase the risk of exposure and transmission of harmful bacteria and viruses to residents and staff throughout the home.

Sources: Observations, interviews with staff, PHO-Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012. [s. 229. (4)]

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 that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 12th day of February, 2021

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

Original report signed by the inspector.