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

Original Public Report

Report Issue Date: May 3, 2023	
Inspection Number: 2023_1611_0001	
Inspection Type: Critical Incident (CI) System	
Licensee: The Regional Municipality of Peel	
Long Term Care Home and City: Tall Pines Long Term Care Centre, Brampton	
Lead Inspector Katherine Adamski (753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.05.04 10:59:39 -04'00'
Additional Inspector(s) N/A	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18-21, 24-26, 2023.

The following intake(s) were inspected:
- Intake: #00001702 and #00004948 – related to an injury of unknown cause
- Intake: #00020194 – related to medication administration
- Intake: #00084240 – related to fall prevention and management
- Intake: #00002797 – related to skin and wound care
- Intake: #00019495 – related to staff to resident abuse

The following intakes were completed in this inspection: intake #00003793, #00004883, and #00006500 related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: MEDICATION ADMINISTRATION

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was prescribed a drug for their medical condition with specific instructions for administration.

A Registered Nurse (RN) administered an amount of the drug more than the amount specified by the prescriber in error. The resident was monitored and remained medically stable.

When the RN failed to ensure that the drug was administered to the resident in accordance with the specified directions, the resident was at risk of experiencing negative side effects related to the overdose of the drug.

Sources: the resident's plan of care including medication orders, electronic Medication Administration Record, and progress notes, interviews with the Supervisor of Care (SOC) and other staff.

COMPLIANCE ORDER CO #001 SKIN AND WOUND CARE

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:

1) All Personal Support Workers (PSW) on a specified neighborhood are educated on the home's Point of Care (POC) documentation, including generating alerts for registered staff, specifically as it relates to documenting observations of new areas of altered skin integrity.

2) All registered staff on a specified neighborhood, including RN #109, #113 and #119, receive education on the home's Skin and Wound Program policies and procedures, specifically as it relates to the registered staffs' responsibility to review alerts generated by PSW's and assess new areas of altered skin integrity, immediately upon being made aware.

3) The education provided to PSW's and registered staff is to be documented including the date provided, who it was provided by, who attended, and the content of the education. This document must be maintained in the home.

4) Conduct a weekly audit of the specified neighborhood's POC documentation, including alerts generated by PSW staff related to new areas of altered skin integrity, to ensure that registered staff completed an initial skin and wound assessment within 12 hours of an alert being documented. Conduct this audit for a period of four weeks. A record of audit must be maintained in the home, and include the date of the audits, the person responsible, and any actions taken for incomplete documentation.

Grounds

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff when an area of altered skin integrity was identified.

Rationale and Summary

A resident was at risk of skin breakdown and pressure ulcers and specific interventions were in place to promote good skin integrity.

A PSW observed new skin concerns on a resident. They reported their observations to a RN that same day and continued to implement the resident's current interventions for promoting good skin integrity. Two other registered staff reported to the SOC that they were aware that the resident was experiencing a new skin concern.

The resident's new skin concerns were not assessed by registered staff and the care plan interventions were not reviewed and revised at this time.

Several days later when the skin concerns were assessed, staging showed that the skin concerns had become progressively worse than when initially observed. Subsequent weekly skin and wound assessments showed that one of the two skin concerns continued to deteriorate showing signs of an infection.

The resident was transferred to hospital for complications likely related to the deterioration of their skin concern. The resident passed away in hospital.

When a resident's newly identified skin concerns were not assessed for several days, appropriate treatment was not immediately implemented, which may have contributed to the deterioration of the skin concern. The resident experienced complications and passed away.

Sources: Investigative notes, a resident's care plan, progress notes, electronic treatment administration record, skin and wound assessments, survey task documentation, interviews with the SOC/Skin and Wound Care Lead and other staff.

This order must be complied with by:
May 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the

licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.