

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: July 9, 2024	
Inspection Number: 2024-1611-0002	
Inspection Type: Complaint Critical Incident (CI)	
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
Additional Inspector(s) Emma Perin (#000869)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11-14, 24-27, 2024.
The following intake(s) were inspected: <ul style="list-style-type: none"> Intake: #00111793 - CI #616-000011-24 and Intake: #00116209 - CI #616-000013-24 - related to infection prevention and control Intake: #00117691 - related to several care concerns

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

- Resident Care and Support Services
- Food, Nutrition and Hydration
- Infection Prevention and Control

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to their code status.

Rationale and Summary

A resident's power of attorney (POA) was not consulted about the resident's code status and wishes by the home.

When the resident's code status was not confirmed with their POA, there was a risk that the resident's wishes were not followed.

Sources: Interviews with the resident's family and staff, the resident's physical and electronic medical documentation. [#753]

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

WRITTEN NOTIFICATION: General Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under the Dietary Services, Nutrition and Hydration Program, including interventions and the resident's responses to the interventions, were documented.

Rationale and Summary

The home's Dietary Services, Nutrition and Hydration Program policy required the home's Registered Dietitian (RD) to document in the electronic health record any interventions.

A resident experienced a significant change to their health status related to nutrition and hydration. In response to this change, the resident's family implemented nutrition and hydration interventions.

Staff made the RD aware of these interventions, however, they were not documented in the resident's electronic health record.

When the RD did not document the interventions implemented by the family, there was incomplete documentation of the resident's intake.

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

Sources: Interviews with the resident's family and staff, the resident's physical and electronic medical documentation. [#753]

WRITTEN NOTIFICATION: Weight Changes

WRITTEN NOTIFICATION: Weight Changes

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 75 1.

Weight changes

s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.

The licensee failed to ensure that the actions and outcomes were evaluated related to resident #002's weight change of over five per cent (%) of body weight in a one-month period.

Rationale and Summary

The home's Dietary Services, Nutrition and Hydration Program policy required the home's RD to regularly follow-up and evaluate the effectiveness of nutrition and hydration interventions. The RD was required to evaluate residents to determine if their nutrition and hydration goals were achieved; if the strategies were effective and if revisions were required.

A resident experienced a significant change to their health status related to nutrition and hydration. In response to this change, the RD implemented an intervention.

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

Over a period of time, the resident's health status did not improve and there were no new interventions implemented, or further monitoring for the effectiveness of nutrition interventions by the RD.

The RD stated that they did not regularly follow-up with the resident, they relied on staff to monitor interventions for effectiveness and inform them if revisions were required.

When the RD did not regularly follow-up with the resident's nutrition interventions for effectiveness, monitoring to evaluate whether nutrition and hydration goals were achieved did not occur and the resident remained below their goal weight.

Sources: Interviews with the resident's family and staff, the resident's physical and electronic medical documentation. [#753]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) was implemented. In accordance with the IPAC Standard, revised September 2023, additional precautions must include both evidence-based practices related to potential contact precaution transmission, as well as appropriate selection and application of Personal Protective

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

Equipment (PPE).

Specifically, the licensee has failed to ensure that the Personal Support Worker (PSW) complied with the appropriate use and application of PPE for the resident who required additional precautions.

Rationale and Summary

A resident required additional precautions when receiving direct care.

The PSW assisted the resident with toileting. The PSW confirmed that they were providing direct care, and that they did not wear a gown during this care.

When the PSW did not follow proper PPE protocol by failing to wear a gown when performing direct care, this put others at risk of cross-contamination.

Sources: Interview with the PSW, observation of signage outside room, observation of the PSW in the resident's room, IPAC Standard, revised September 2023. [#000869]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)

Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

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

The licensee has failed to ensure that any standard issued by the Director with respect to IPAC implemented. In accordance with O. Reg. 246/22 s. 259 (2) d, the licensee has failed to ensure that staff orientation included respiratory etiquette.

Rationale and Summary

The home's IPAC Lead provided the Inspector with the home's orientation training materials which did not include information regarding respiratory etiquette.

The IPAC Lead confirmed that respiratory etiquette was not provided in the staff orientation.

Sources: Interview with IPAC Lead, Orientation documents. [#000869]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)

Orientation

s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was implemented. In accordance with O. Reg. 246/22 s. 259 (2) h, the licensee has failed to ensure that staff orientation included handling and disposing of biological and clinical waste.

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

Rationale and Summary

The IPAC Lead provided the Inspector with the home's orientation training materials on which did not include information regarding handling and disposing of biological and clinical waste.

The IPAC Lead confirmed that handling and disposing of biological and clinical waste was not provided in the staff orientation.

Sources: Interview with IPAC Lead, Orientation documents. [#000869]