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
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: March 21, 2025
Inspection Number: 2025-1611-0002
Inspection Type: Critical Incident
Licensee: The Regional Municipality of Peel
Long Term Care Home and City: Tall Pines Long Term Care Centre, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 19, 20, 21, 2025.

The following Critical Incident (CI) intake was inspected:

- Intake: #00138069 related to alleged abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that the alleged abuse of a resident was immediately investigated.

A resident reported an allegation of abuse to the staff of the home, however, it was not immediately investigated.

Sources: Resident's progress notes; Interviews with the Supervisor of Care (SOC), Social Worker (SW), and the Administrator.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an allegation of abuse was immediately reported to the Director.

A resident reported an allegation of abuse to the staff of the home, however, this

was not reported to the Director.

Sources: Resident's progress notes, e-mail correspondence; Interviews with the SOC, SW, and the Administrator.