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
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 24, 2023

Inspection Number: 2023-1573-0003

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Peel Manor, Brampton

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2023.10.24 14:52:29 -04'00'

Additional Inspector(s)
Sharon Perry (155)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 26-29, 2023, and October 4-6, 2023

The following Critical Incident (CI) intakes were inspected:

- Intake: #00015977 regarding a COVID-19 outbreak.
- Intake: #00089458 regarding an allegation of resident abuse.
- Intake: #00090951 regarding the home's medication management system.
- Intakes: #00093935 and #00097118 regarding the home's falls prevention and management program.

The following Complaint intake was inspected:

- Intake: #00093560 regarding concerns about a resident's care.

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

Resident Care and Support Services
Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a resident was administered a medication as ordered by the physician.

Rationale and Summary:

A laboratory report said that a particular blood electrolyte levels of a resident was low.

A physician's telephone order was obtained to administer the resident a medication to manage the low blood electrolyte levels. However, the registered staff who obtained the telephone order misheard the physician's order and transcribed another type of medication.

As a result, the resident received the wrong medication and was negatively impacted.

Sources: a resident's medication administration record, a physician's digital prescriber's record, a medication incident original report, and interviews with staff. [606]

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to report to the Director the results of their investigation undertaken for an allegation of abuse of a resident.

Rational and Summary:

The licensee submitted a Critical Incident System (CIS) regarding an incident of alleged

emotional abuse of a resident.

The CIS was not amended to include the results of their investigation.

When the Director was not made aware of the outcome of the investigation, it may have delayed prompt follow-up and response from the Director.

Sources: a CIS, interview with the Acting Director of Care. [155]