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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Original Public Report

Report Issue Date: September 20, 2024

Inspection Number: 2024-1573-0002

Inspection Type:
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Peel Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 30, and September 4-6, 2024

The following Critical Incident System (CIS) intakes were inspected:

- Intake #00114685 and intake #00123779 regarding the home's outbreak management program.
- Intake #00119851 regarding the home's fall prevention and management program

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure safe positioning techniques were used for a resident.

Rationale and Summary:

A resident sustained an injury when two Personal Support Workers (PSW) did not use proper positioning techniques when providing them with care.

A Supervisor of Care (SOC) said the two PSWs should have considered ensuring the resident's safety and risk of falling when positioning the resident in bed.
Failure to use safe positioning techniques for the resident resulted in the resident to fall and sustain an injury.

Sources: A resident's clinical records, the home's falls prevention and management program, the home's investigation records, and interviews with staff. [606]