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

Public Report

Report Issue Date: October 9, 2025

Inspection Number: 2025-1611-0005

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 date(s): September 23, 25-26, 29, 2025 and October 1-3, 7-9, 2025.

The following intake(s) were inspected:

- Intake: #00152968, related to infection prevention and control.
- Intake: #00155892, related to prevention of abuse and neglect.
- Intake: #00155890, related to resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse by a co-resident.

The Personal Support Worker (PSW) found co-resident having inappropriate interaction with the resident.

Sources: Residents clinical record and Interviews with staff and Director of Care.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that three residents with symptoms that indicated

the presence of infection were monitored every shift.

Sources: Critical Incident Report, resident assessments, IPAC Standard for Long-Term Care Homes, email from Director of Care, and interview with the IPAC Lead.

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

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

1. An interdisciplinary assessment is completed and documented for resident #002, that should include participation from the BSO staff, social worker and other appropriate members of the interdisciplinary team, as well as feedback from staff observations, to identify contributing factors and triggers leading to harmful interactions.

2. The Substitute Decision Maker (SDM) is provided the opportunity to participate in the planning and implementation of interventions to meet individual needs and ensure the safety of resident #002.
3. The plan of care for resident #002 is updated with identified, individualized interventions and should be re-evaluated for effectiveness
4. All steps taken for parts 1) to 3) are documented. This shall include any assessments completed, triggers or interventions identified, the names of individuals who participated, and the dates that actions took place.

Grounds

The licensee failed to ensure that steps were taken to minimize the risk of harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the leadership team through observation by the staff, that could potentially trigger such altercations; and further identifying and implementing interventions.

A resident was known to have responsive behaviours.

On one occasion, a co-resident had an inappropriate interaction with the resident.

An interdisciplinary assessment was not conducted to determine potential triggers or identify and develop interventions to prevent another incident from happening.

A second incident happened wherein the co-resident had another inappropriate interaction with the resident.

Following the second incident between the residents, BSO and Social Worker (SW) assessments were not completed as per the home's procedures

As a result of not implementing measures to prevent further harmful interactions, there was another incident between the residents.

Sources:

Residents' clinical records; and Interviews with staff, Supervisor of Care and Director of Care.

This order must be complied with by

October 31, 2025

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

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.