Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2014	2014_207147_0024	H-001194-14 AND H-001349-14	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

Long-Term Care Home/Foyer de soins de longue durée

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 7, 8 and 14, 2014

H-001194-14
H-001349-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered staff, Behavioural Support of Ontario (BSO) staff and Personal support workers (PSW).

During the course of the inspection, the inspector(s) reviewed residents clinical records, internal investigation notes, policy and procedures related to Falls Management, Pain, Responsive Behaviours, Head injury routine and Code White.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Reporting and Complaints
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

On an identified date in September 2014 resident #100 was overheard screaming from their room. The registered nurse responded to the resident and found resident #200 physically assaulting resident #100.

A. According to the home's Emergency Code White policy - Malton Village Emergency Plan - Annex XVI - defines Code White as "an incident requiring urgent assistance" such as presentation of responsive behaviour by any person which creates an immediate risk of harm.

Interview with the registered nurse who responded to the incident and review of the home's internal investigation notes confirmed that this incident satisfied the definition of a code white.

B. As per home's Prevention and Management of Responsive Bahaviour Program - last revised on May 5, 2014 related to a potential or actual crisis - the registered staff are to complete the Risk Management Report in the electronic health record for the resident exhibiting the behaviour and the recipient of the behaviour.
Interview with the Supervisor of Care (SOC), the registered staff and the review of the resident's electronic health records, a Risk Management Report was not completed by the registered staff after the incident. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #100 was protect from abuse by anyone.

On an identified date in September 2014 resident #100 was overheard screaming from their room. The registered nurse responded to the resident and found resident #200 physically assaulting resident #100.

Interview with the registered staff and review of the home's internal investigation notes confirmed that resident #200 was toileted by the psw staff earlier during the shift and put back to bed as per the resident's plan of care.

According to resident #100 clinical records and interview with the staff, resident #100 was on anti-coagulants and was observed to be bleeding after the physical assault. Resident #100 was subsequently sent to hospital for further medical assessment and treatment. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every licensee of a long-term care home shall protect residents from abuse by anyone., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to 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.

On an identified date in September 2014 resident #100 was overheard screaming from their room. The registered nurse responded to the resident and found resident #200 physically assaulting resident #100.

Review of resident #100's health records and interview with the registered staff confirmed that the resident was on anti-coagulants. Interview with the registered staff who responded to the incident stated that the resident #100 was observed to be bleeding, however due to resident #200 continuing to be exhibiting responsive behaviours, the registered staff was not able to complete vital signs, a head to toe assessment and assess resident #100's injuries, until police and paramedics arrived. Review of the resident #100's electronic health records also confirmed that there were no documentation an initial assessment or the resident's response to any interventions were documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
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. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, 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 identifying and implementing interventions.

Review of resident #200's admission packaged from Community Care Access Center (CCAC) Behavioural Assessment Tool completed prior to admission to the home, showed that the resident was exhibiting numerous responsive behaviours towards staff and family. BSO involvement and a soft calm approach were recommended to help transition into Long term care.
However, interview with the home's BSO team and review of the resident's plan of care, indicated that there were no strategies put in place at the time of admission to ensure that potential triggers such as altercations with staff and others in the home were identified and implemented.
Resident #200 subsequently had two altercations with two different residents on two different dates. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, 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 identifying and implementing interventions., to be implemented voluntarily.

Issued on this 14th day of November, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs