



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2014	2014_337581_0012	H-0000022-14	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

DIANNE BARSEVICH (581)

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): July 10, 11, 2014.

During the course of the inspection, the inspector(s) spoke with Supervisor of Care, Registered Staff, Personal Support Worker(PSW) and family.

During the course of the inspection, the inspector(s) reviewed health care records, investigation reports, relevant policies and procedures and practices.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :



The licensee did not ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

The plan of care for resident #301 identified they were reassessed for bed rails post-fall in 2013. Bed Rail Risk Assessment completed in 2013, indicated the resident now required two bed rails as a Personal Assistance Service Device (PASD) for safety and to assist with bed mobility. The use of bed rails was not documented in the written plan of care or kardex after the resident's care needs changed. The Supervisor of Care confirmed that the written plan of care was not revised and updated. [s. 6. (10) (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 to ensure each resident's plan of care is reviewed and revised when their care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement



Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

- 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 3. The use of the PASD has been approved by,**
 - i. a physician,**
 - ii. a registered nurse,**
 - iii. a registered practical nurse,**
 - iv. a member of the College of Occupational Therapists of Ontario,**
 - v. a member of the College of Physiotherapists of Ontario, or**
 - vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
- 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
- 5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

Findings/Faits saillants :

The licensee did not ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in the resident's plan of care if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

The plan of care for resident #301 identified they required two bed rails raised when in bed for safety and positioning. The clinical record was reviewed and did not include consent for bed rails as a PASD. Supervisor of Care confirmed there was no consent for bed rails. [s. 33. (4) 4.]



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Issued on this 26th day of September, 2014

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