



**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**

**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**

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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 10, 2015	2015_300560_0006	H-002083-15	Critical Incident System

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### **Licensee/Titulaire de permis**

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

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

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

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

SUSAN PORTEOUS (560)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 31, 2015 and April 1, 2015.**

**This was an off-site inspection conducted by telephone of Critical Incident log # H-002083-15.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC) and reviewed documentation.**

**The following Inspection Protocols were used during this inspection:  
Critical Incident Response**

**During the course of this inspection, Non-Compliances were issued.**

- 1 WN(s)**
- 0 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**



**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
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

- 1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).**
- 2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**
- 3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**
- 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**
- 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**
- 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was immediately informed of a disease outbreak at the home declared by Public Health on February 18, 2015. [O.Reg. 79/10 s.107(1)(5)]

The Critical Incident Report M618-000007-15 identified that a disease outbreak declared at the home on February 18, 2015 was not reported to the Director until the Critical Incident Report was submitted on February 25, 2015.

The DOC confirmed that the home did not immediately report the outbreak to the Director. [s. 107. (1)]

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**Issued on this 14th day of April, 2015**

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

**Original report signed by the inspector.**