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**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 12, 2016 | 2016_343585_0001 | 035885-15 | Resident Quality Inspection |

### 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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): January 4, 5, 6, 7, 8, 12, 13, 14 and 15, 2016.**

**Seven critical incident system (CIS) inspections log #019237-15 and #004653-15 related to nursing care, #029353-15 related to abuse, #023852-15 and #003403-15 related to falls, #009956-15 related to transfers, #002801-14 related to responsive behaviours, and one complaint inspection log #005528-14 related to nursing care were conducted concurrent to the resident quality inspection (RQI).**

**During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, personal support workers (PSW), volunteers, dietary staff, supervisors of care, director of care, dietary services supervisor, registered dietitian, activation and volunteers supervisor, resident assessment instrument (RAI) coordinator, physiotherapist and the administrator.**

**During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed records including but not limited to clinical health records, policies and procedures, staffing schedules, menus, meeting minutes, training records, staff files and program evaluations.**

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

**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Sufficient Staffing**
**Trust Accounts**

**During the course of this inspection, Non-Compliances were issued.**
- **9 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 protect resident #012 from abuse by staff in the home.

On an unspecified date in January 2016, resident #012 brought forth allegations to Long-Term Care (LTC) Homes Inspector #528 that they received rough care by a staff member, which resulted in pain. The resident reported that they told supervisor of care (SOC) #002 approximately one month earlier and since they came forward, they continued to receive rough care by the staff member. LTC Homes Inspector #528 immediately brought forward allegations to SOC #002, at which time the SOC indicated that they were aware of some aspects of resident #012's concerns related to pain during care.

Review of the resident's clinical progress notes revealed that in December 2015, registered practical nurse (RPN) #118 documented that the resident was complaining of having difficulty with staff to receive proper care. In an interview with RPN #118 in January 2016, they confirmed they were asked by SOC #002 to supervise care provided to resident #012 by personal support worker (PSW) #135. The RPN explained that they asked SOC #002 why they were to supervise the care, and was advised that it was related to concerns of mistreatment from the resident. RPN #118 indicated that during their supervision of care, due to concerns of how PSW #135 was providing care to the resident, the RPN completed some aspects of care on their own; however, was not present to supervise for all of the care. RPN #118 confirmed that they did not discuss what happened during their supervision with SOC #002. RPN #118 also reported in the interview of an incident approximately two weeks later, when PSW #135 had to be reminded to complete care for one resident, which was not reported to SOC #002.

On an unspecified date in December 2015, the resident's written care plan was updated to include that two staff were required to assist with the unspecified activity of daily living (ADL) as much as possible to help prevent injury and pain.

On an unspecified date in January 2016, PSW #135 was interviewed and confirmed that when RPN #118 was present to observe care in December 2015, both staff assisted with the some but of not all aspects of care. PSW #135 also confirmed that they were aware that RPN #118 was asked to supervise them providing care for resident #012 because of the resident's concerns.

On an unspecified date in January 2016, an interview was held with SOC #002 who identified documentation from April 2015, where resident #012 reported concerns related to care and respect by PSW #135. SOC #002 confirmed that concerns from the resident were not investigated and PSW #135 remained a regular staff for the home area. SOC #002 also confirmed that on an unidentified date after September 2015, RPN #101

reported concerns of whether PSW #135 was actually providing care to residents and confirmed that those concerns were not investigated. SOC #002 confirmed that after asking RPN #118 to supervise PSW #135 provide care to resident #012, no formal follow up was completed; and PSW #135 remained a regular care staff on resident #012's home area. SOC #002 also confirmed that PSW #135 approached the SOC and was concerned that they were being supervised.

From December 2015 to January 2016, PSW #135 was responsible for completing aspects of care to resident #012 on four occasions. On an unspecified date in January 2016, PSW #135 was removed from providing care to the resident and an investigation was initiated. Interview with SOC #002 confirmed that as a result of the home's investigation, allegations of abuse were substantiated.

Throughout the course of the inspection, it was identified that home was aware of resident #012's care concerns with PSW #135 and failed to follow up on those concerns until it was reported to the home by the LTC Homes Inspector in January 2016. In December 2015, staff were aware of allegations of PSW #135 mistreating the resident; however, the PSW continued to provide care to the resident. The home failed to protect the resident from abuse. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) In 2015, resident #042 sustained an injury while being transferred by PSW #136 with the sit to stand lift. Review of the investigation notes revealed that the PSW transferred the resident with one staff. Review of the home's policy, Minimal Lift Program indicated "it is mandatory that two staff are present when using the mechanical lift, one to operate the lift and the other to guide the resident in the sling". Interview with PSW #136 and registered staff #105 confirmed that the resident was transferred with the sit to stand lift with one staff and sustained an injury. Registered staff #105 confirmed that PSW #136 did not ensure that safe transferring techniques were used when assisting resident #042.

B) In January 2016, resident #012 was observed sitting in a wheelchair with a missing component. In an interview with the resident, they revealed that the chair had been broken for several weeks, causing discomfort as a result of poor positioning. The written plan of care identified that the resident required assistance with transferring and positioning and routinely sat in the chair for 12 hours. Interview with PSW #120 and review of the progress notes confirmed that the resident's chair had been broken since December 2015. Staff did not ensure that the the resident was positioned safely when using the wheelchair for approximately three weeks. [s. 36.]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**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 :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #004's plan of care indicated they required a continence product. Interview with registered staff #101 and PSW #102 stated the resident used the continence product on all shifts which was changed on an unspecified shift. The written plan of care noted the resident used a continence product; however, did not include when it was changed. Interview with registered staff #100 confirmed that the continence product was changed daily, was planned care for the resident and was not included in the plan of care. [s. 6.

(1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

A) In January 2016, resident #012 was observed in a wheelchair. The resident reported that by the end of the day, their back was sore from sitting up right and that they would like more frequent rest periods. Review of the resident's written plan of care identified they preferred starting days early and once up, remain in their wheelchair for the day and take naps on and off in the chair. In another area of the written plan of care, it noted they required rest periods in the day and for staff to listen for resident's request to be transferred to bed. In addition, the plan identified they had ongoing issues with pain and required routine repositioning and rest periods throughout the day. Interview with registered staff #101 confirmed that the resident had ongoing issues with pain and remained seated at 90 degrees in their wheelchair most days. Staff also confirmed that the resident was not routinely transferred to bed for rest during the day unless requested and the written plan of care was unclear as to the resident's preferences for rest periods.

B) Resident #006's plan of care identified they required a specific type of continence product on all three shifts, which as also reported by PSW #131. Upon further review, the written plan of care used to direct PSWs indicated the resident wore a different type of continence product than what was reported by PSW #131 and noted in the plan of care. Interview with registered #134 stated that that resident wore the continence product as noted in the plan of care and confirmed the written plan of care did not provide clear directions to staff related to the type of continence product required.

C) Resident #012's plan of care identified they were on program for routine toileting. Interview with PSW #121 and registered staff #124 revealed that the resident was incontinent at times; however, capable of requesting assistance and not on a toileting program. The plan of care was not clear related to strategies for direct care staff to manage the resident's level of incontinence.

D) In January 2016, the written plan of care for resident #012 identified they had pain related to impaired mobility and required two staff to assist in an aspect of care as much as possible to help prevent injury and pain. Interview with PSW #135 and #121 and registered staff #117 confirmed that the resident had complaints of pain. Interview with registered staff #118 confirmed that the resident required gentle care and extensive assistance to avoid pain. The interventions in the written care plan directing staff to

assist the resident with care were unclear, related to, how staff were to manage the resident's pain related to impaired mobility in an unspecified area. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) In April 2015, a bed risk assessment for resident #006 identified they required two bed rails when in bed as a personal assistance services device (PASD). Review of the plan of care revealed that a PASD assessment was completed by registered staff monthly starting in May 2015, which indicated they required two bed rails raised when in bed. In January 2016, the resident was observed in bed with two bed rails raised. Review of the Minimum Data Set (MDS) assessment completed in July and October 2015, indicated the resident did not use bed rails. Interview with registered staff #100 confirmed the resident required bed rails since April 2015 and the MDS assessments were not consistent with the bed risk and PASD assessments and staff did not collaborate with each other in their assessments related to the use of the bed rails.

B) In May 2015, a MDS assessment for resident #001 identified they were occasionally incontinent. In August 2015, the MDS assessment indicated they were continent of bladder and the Resident Assessment Protocol (RAP) revealed their incontinent status remained unchanged. Interview with registered staff #114 confirmed that the MDS and RAP assessments completed in August 2015, were not consistent with the previous assessment, when it was noted there was no change in their incontinence and it should have been assessed as an improvement.

C) In April, July and October 2015, MDS assessments completed for resident #004 indicated they required a continence product. Review of the written plan of care noted they used different type of continence product than what was documented in the MDS assessment. Interview with registered staff #101 stated the resident used the continence product that was specified in the written plan of care, not the MDS assessment, and confirmed that their assessments of the resident's continence care needs were inconsistent.

D) In April 2015, a MDS assessment completed for resident #004 indicated they were frequently incontinent. In July 2015, a MDS assessment indicated they were occasionally incontinent. Interview with registered staff #100 stated there was a change in the resident's continence between quarterly assessments, however; was coded as no

change. Registered staff #100 confirmed that the assessments were not consistent with each other and should have been coded as an improvement.

E) In February 2015, resident #040 experienced a fall which resulted in injury. Review of a MDS significant change assessment completed in March 2015 identified the resident did not have a fall in the past 30 days. Interview with registered staff #100 confirmed that when the March MDS assessment was completed, the resident fell within the last 30 days, and confirmed the MDS assessment was not consistent with the post falls assessment.

F) In December 2015, the MDS assessment completed for resident #007 indicated the resident had an infection. Review of clinical progress notes did not indicate the resident had an infection. Interview with registered staff #103 confirmed the resident did not have an infection during the review period, and staff did not collaborate with each other in the assessment of the resident.

G) In July 2015, a MDS assessment completed for resident #006 noted they were frequently incontinent. In October 2015, a MDS assessment identified they were continent but failed to identify their continence had changed. Interview with registered staff #134 confirmed there was an improvement in the resident's continence and their assessments were not consistent with each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the plan of care was provided to the resident as specified in the plan.

A) Resident #064's plan of care stated they were to receive specific fluids at a meal. In January 2016, during a meal observation, PSW #132 did not provide the resident with fluids as specified in their plan of care, which they confirmed in an interview.

B) Resident #012's plan of care identified they had ongoing complaints of pain with impaired mobility and on an unspecified date in 2015, was updated to include an intervention for two staff to assist the resident with an unspecified ADL to help prevent injury and pain. Review of point of care (POC) documentation completed by PSWs identified 17 times where direct care staff provided one person physical assistance with the ADL, which was confirmed by PSW #135, #121 and #120. The plan of care was not provided to the resident as specified in the plan, related to assistance required with the ADL. [s. 6. (7)]

5. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) Resident #004's written plan of care indicated they required a continence product that was to applied and removed at specified times. Interview with registered staff #101 stated that the resident required the continence product at all times and confirmed the written plan of care was not revised when their continence care needs changed.

B) In December 2015, resident #006 was sent to hospital and diagnosed with an injury as a result of a fall. Review of the written plan care revealed that in January 2016, changes were made to the resident's transfer, mobility and ambulation status, and included updated therapeutic devices as a result of the fall. Interview with registered staff #100 confirmed that the written plan of care was not updated until five days after the resident returned from hospital when their care needs had changed related to transfers, mobility, ambulation and therapeutic devices.

C) Resident #011's plan of care included a goal weight, effective August 2013. In August 2015, the resident experienced a significant weight change over two months. Interview with the registered dietitian (RD) confirmed resident's goal weight changed following the weight change and the plan of care was not revised regarding their goal.

D) Resident #011's plan of care stated they required total assistance of one staff with eating. Interview with PSW #131 and registered staff #114 both reported the resident ate independently, and accepted cueing and encouragement with eating. Interview with the RD confirmed the resident no longer required total assistance and the plan of care was not revised when the care was no longer necessary.

E) Resident #002's plan of care indicated they required an adaptive eating device. During a meal observation in January 2016, the resident did not receive the adaptive device as noted in their plan of care. Dietary staff #104 reported that the resident no longer served on the adaptive eating device, which was confirmed by the RD and the plan of care was not revised when the care set out in the plan was no longer necessary. (585)

F) Resident #009's plan of care stated they used a PASD. Interview with registered staff #134 confirmed the resident no longer used the PASD and the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

G) In May 2015, resident #042 sustained an injury while being transferred with the sit to stand lift. Following the injury, the physiotherapist completed an assessment and outlined interventions required to be implemented regarding positioning, toileting, bathing and transferring. Review of the written plan of care revealed that the only the revision to the plan was related to transfers post injury. Interview with registered staff #105 confirmed that the written plan of care was not revised when their care needs changed post injury.

H) In February 2015, resident #040 fell, resulting in injury. In March 2015, the resident was transferred back to the home and assessed in MDS as a significant change. According to the home's policy on re-admission from hospital, residents' care plans were to be updated within 24 hours of readmission. Review of the plan of care indicated that the resident had a change in mobility, locomotion, and transfers. Interview with registered staff #100 confirmed that the resident's status had significantly changed post hospital admission and their written plan of care was not revised until 12 days after readmission to the home. [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 and ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; care set out in the plan of care is provided to the resident as specified in the plan; and, the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy "Prevention, Reporting and Elimination of Abuse/Neglect: LTC1-05.01" defined physical abuse including but not limited to using force or handling of a resident/client in a rough manner. When abuse is suspected, the policy stated "a person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information which it is based to the Director". Directions for investigating suspected or witnessed abuse/neglect, included but were not limited to, an immediate investigation and if it resulted out of an employee's action or inaction, the employee was to be immediately be placed on a leave of absence pending further investigation.

On an unspecified date in January 2016, resident #012 reported to LTC Homes Inspector #528 that they had been treated roughly by staff. The resident also reported that they notified the home about a month earlier, and continued to receive rough care by the staff member.

i) When SOC #002 was notified of the allegations by inspector #528 on on an unspecified date in January 2016, they identified that they were aware of some aspects of the resident's complaints of pain during care by PSW #135. Eight days later, SOC #002 denied being aware of any allegation of mistreatment of the resident until they were notified by the inspector #528 on the unspecified date in January 2016.

ii) On an unspecified date in January 2016, registered staff #118 reported in an interview that in December 2015, they were asked by the SOC #002 to supervise PSW #135 provide care to resident #012 because of rough treatment.

iii) On an unspecified date in January 2016, PSW #135 confirmed in an interview that

RPN #118 was present before and after the care of resident #012 on an unspecified date in December 2015, and when asked why they were supervising, replied the resident was afraid of the them. PSW #135 also indicated that resident #012 was present for this conversation.

vi) On an unspecified date in January 2016, the home began investigating allegations after inspector #528 spoke with SOC #002. On a later date in January 2016, SOC #002 identified in the interview that nine months prior, resident #012 verbalized concerns about PSW #135 to SOC #002; however, no follow up was completed. The SOC #002 also confirmed that no action was taken to address concerns of two residents who did not receive care as scheduled by PSW #135. After an unspecified date in December 2015, when staff RPN #118 and PSW #135 were aware of concerns of rough handling, PSW #135 provided care to resident #012 on four occasions.

The home did not follow the policy related to immediate reporting, investigation, and suspension of PSW #135 pending investigation of alleged abuse after an unspecified date in December 2015. [s. 20. (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 and ensuring that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

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

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,**
**(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A) On an unspecified date in January 2016 during a meal, resident #082 was observed seated in a chair tilted greater than 45 degrees. PSW #132 was feeding the resident and the resident was coughing while eating. The PSW reported the resident was always tilted and could not identify that they were in an unsafe position for feeding. Review of the plan of care identified that the resident was a high nutritional risk related to chewing/swallowing difficulty and was on a modified texture and fluid diet. Interview with RD confirmed that the resident should be seated at 90 degrees during meals if coughing occurs to ensure safe positioning.

B) Resident #002's plan of care stated they were a high nutrition risk related to swallowing and chewing issues and had a history of coughing while eating, as confirmed by the RD. Their plan of care stated they were to receive total assistance with eating, with an intervention for staff to use either a specified utensil or provide modified oral portions. During a meal on an unspecified date in January 2016, the resident was observed reclined in a tilt wheel chair, receiving total assistance from volunteer #111.

The volunteer was noted feeding the resident using a utensil and providing portions larger than what was specified in their plan of care. Registered staff #105 reported the resident was at risk for aspiration, confirmed they were in an unsafe position for eating and not provided with the appropriate portions for eating. The RD confirmed there was a history of staff not feeding the resident appropriately.

C) On an unspecified date in January 2016, during a meal:

i) Resident #082 was seated in a reclined position, receiving assistance with feeding from volunteer #137. The resident's plan of care stated they were to be positioned at a 90 degree angle for eating. Registered staff #134 confirmed the resident was not positioned as indicated in their plan of care.

ii) Resident #009 was observed seated in a wheel chair, slouched with their hips and feet pushed out from the chair, receiving total assistance by volunteer #137. The resident's plan of care stated they were to be positioned at 90 degree angle for meals. Registered staff #134 confirmed the resident was not positioned appropriately for eating.

iii) Resident #087 was observed slouching in their wheelchair, with a gap between the resident and the chair back. PSW #138 assisting the resident confirmed they were slouched. Registered staff #134 confirmed the resident was not positioned appropriately for eating. [s. 73. (1) 10.]

2. The licensee failed to ensure that the home had a dining and snack service that included appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

A) During a meal on an unspecified date in January 2016, resident #063 was observed seated at the edge of a wheelchair seat, lacking back support. Interview with PSW #132 revealed that the resident could not be positioned appropriately in the chair for meals as it had been in disrepair for two months. Interview with registered staff #100 confirmed that the resident was not in comfortable position during dining.

B) During a meal on an unspecified date in January 2016, resident #085 was observed sitting in wheel chair in a reclined position, reaching across their torso reach the table. The resident stated they could not reach the table comfortably and that they wanted to be

seated in a more upright position; however, their chair could not be adjusted to do so. The resident also stated their legs rubbed against the bottom of the table as a result of their position. PSW #131 and registered staff #114 confirmed the chair could not be adjusted to seat the resident appropriately while eating. Registered staff #114 also confirmed the resident was not provided a seating position and appropriate table height to eat comfortably. [s. 73. (1) 11.]

3. The licensee failed to ensure that no person simultaneously assisted more than two residents who required total assistance with eating or drinking.

During a meal on an unspecified date in January 2016, PSW #119 was observed providing total assistance to resident #008, #080 and #086. PSW #119 stated the residents required total assistance and they were providing assistance simultaneously as they did not want the resident #080 to wait. Registered staff #134 confirmed resident #008, #080 and #086 required total assistance, as well as several other residents in the dining room, and at times there was insufficient assistance available for feeding at meals. The registered staff confirmed no person was to assist more than two residents requiring total assistance simultaneously. [s. 73. (2) (a)]

***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 and ensuring that the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance and appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD**

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

**s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,**
**(a) is well maintained; O. Reg. 79/10, s. 111. (2).**
**(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).**
**(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a PASD used under section 33 of the Act, was well maintained.

In January 2016, resident #085 was observed with a PASD applied. They reported they always required the PASD and it caused discomfort due its poor condition. The PASD was observed to have no padding in an area that made direct contact with the resident's body. Interview with PSW #131 and #133 reported they were aware the PASD was in poor repair for several months. E-mails regarding the resident's PASD were reviewed and revealed that in November 2015, the social worker noted that the poor condition of the PASD was impeding the resident's ability to participate in outings and impacting their quality of life. Review of the home's service request log revealed no service requests were made for the PASD when it was known by staff to be in poor condition, which was confirmed by a Motion Specialties representative. SOC #002 stated the PASD had been in poor condition for several months, acknowledged it caused the resident discomfort and at the time of the interview was not aware of any solution in place to improve the condition of the PASD. [s. 111. (2) (a)]

***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 and ensuring that a PASD used under section 33 of the Act is well maintained, to be implemented voluntarily.***

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**WN #7: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the "Admission/Transfer/Discharge/Leave of Absence- Readmission From Hospital, Policy No: LTC9-05.10.01", effective date, November 4, 2010, directed registered staff to complete the following assessment in Point Click Care (PCC) within 24 hours when a resident returned from hospital: risk of falls assessment, bladder and bowel assessment, skin breakdown risk, pain assessment, complete head to toe, heat assessment and the care plan would be updated within 24 hours of return.

In February 2015, resident #040 experienced a fall resulting in injury and was hospitalized for two weeks. Review of the plan of care indicated that risk of falls assessment, bladder and bowel assessment and skin breakdown risk assessment were not completed when the resident returned from hospital in March 2015. Interview with registered staff #100 confirmed that the three assessments were not completed when the resident returned back to the home after hospitalization and the home's policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

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

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

In January 2016, communication and response systems were not observed in three outdoor areas: the morning star courtyard, redstone courtyard and the reflective garden. The administrator confirmed the areas were used by residents and did not contain communication and response systems. [s. 17. (1) (e)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

On an unspecified date in October 2015, two PSW staff provided care to resident #005. According to PSW #129 and #130, the resident resisted the care and demonstrated responsive behaviours. Review of the plan of care identified that the resident demonstrated responsive behaviours daily when resisting care related to cognitive impairment and directed staff to allow for flexibilty in routine, if resistive give resident space and re-approach, try later, or call the resident's family. Review of the home's investigation notes and interview with BSO staff #122 confirmed that on the unspecified date in October 2015, staff did not implement interventions in response to resident #005 when they resisted care and demonstrated responsive behaviours. [s. 53. (4) (b)]

**Issued on this 24th day of February, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**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**

**Public Copy/Copie du public**

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581) |
| **Inspection No. / No de l'inspection :** | 2016_343585_0001 |
| **Log No. / Registre no:** | 035885-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 12, 2016 |
| **Licensee / Titulaire de permis :** | THE REGIONAL MUNICIPALITY OF PEEL<br>10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9 |
| **LTC Home / Foyer de SLD :** | MALTON VILLAGE LONG TERM CARE CENTRE<br>7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jessica Altenor |

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

**Order / Ordre :**

The home shall ensure all residents, including resident #012 are protected by abuse by ensuring that all allegations of care concerns from staff or residents are immediately investigated and actions taken accordingly.

**Grounds / Motifs :**

1. On an unspecified date in January 2016, resident #012 brought forth allegations to Long-Term Care (LTC) Homes Inspector #528 that they received rough care by a staff member, which resulted in pain. The resident reported that they told supervisor of care (SOC) #002 approximately one month earlier and since they came forward, they continued to receive rough care by the staff member. LTC Homes Inspector #528 immediately brought forward allegations to SOC #002, at which time the SOC indicated that they were aware of some aspects of resident #012's concerns related to pain during care.

Review of the resident's clinical progress notes revealed that in December 2015, registered practical nurse (RPN) #118 documented that the resident was complaining of having difficulty with staff to receive proper care. In an interview with RPN #118 in January 2016, they confirmed they were asked by SOC #002 to supervise care provided to resident #012 by personal support worker (PSW) #135. The RPN explained that they asked SOC #002 why they were to supervise the care, and was advised that it was related to concerns of mistreatment from the resident. RPN #118 indicated that during their supervision of care, due to concerns of how PSW #135 was providing care to the resident, the RPN completed some aspects of care on their own; however, was not present to supervise for all of the care. RPN #118 confirmed that they did not discuss what happened during their supervision with SOC #002. RPN #118 also reported in the interview of an incident approximately two weeks later,

when PSW #135 had to be reminded to complete care for one resident, which was not reported to SOC #002.

On an unspecified date in January 2016, PSW #135 confirmed in an interview that when RPN #118 was present to observe care in December 2015, both staff assisted with the some but of not all aspects of care. PSW #135 also confirmed that they were aware that RPN #118 was asked to supervise them providing care for resident #012 because of the resident's concerns.

On an unspecified date in January 2016, an interview was held with SOC #002 who identified documentation from April 2015, where resident #012 reported concerns related to care and respect by PSW #135. SOC #002 confirmed that concerns from the resident were not investigated and PSW #135 remained a regular staff for the home area. SOC #002 also confirmed that on an unidentified date after September 2015, RPN #101 reported concerns of whether PSW #135 was actually providing care to residents and confirmed that those concerns were not investigated. SOC #002 confirmed that after asking RPN #118 to supervise PSW #135 provide care to resident #012, no formal follow up was completed; and PSW #135 remained a regular care staff on resident #012's home area. SOC #002 also confirmed that PSW #135 approached the SOC and was concerned that they were being supervised.

From December 2015 to January 2016, PSW #135 was responsible for completing aspects of care to resident #012 on four occasions. On an unspecified date in January 2016, PSW #135 was removed from providing care to the resident and an investigation was initiated. Interview with SOC #002 confirmed that as a result of the home's investigation, allegations of abuse were substantiated.

Throughout the course of the inspection, it was identified that home was aware of resident #012's care concerns with PSW #135 and failed to follow up on those concerns until it was reported to the home by the LTC Homes Inspector in January 2016. In December 2015, staff were aware of allegations of PSW #135 mistreating the resident; however, the PSW continued to provide care to the resident. The home failed to protect the resident from abuse. (528)

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Mar 11, 2016

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee must ensure that staff use safe transferring and positioning devices or techniques when assisting residents, including but not limited to ensuring that mechanical lift transfers are conducted by a minimum of two staff.

**Grounds / Motifs :**

1. In 2015, resident #042 sustained an injury while being transferred by PSW #136 with the sit to stand lift. Review of the investigation notes revealed that the PSW transferred the resident with one staff. Review of the home's policy, Minimal Lift Program indicated "it is mandatory that two staff are present when using the mechanical lift, one to operate the lift and the other to guide the resident in the sling". Interview with PSW #136 and registered staff #105 confirmed that the resident was transferred with the sit to stand lift with one staff and sustained an injury. Registered staff #105 confirmed that PSW #136 did not ensure that safe transferring techniques were used when assisting resident #042. (581)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Feb 29, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 12th day of February, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Leah Curle

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office