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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2019	2019_769646_0002	027050-17, 003210-18, 013006-18, 016660-18, 021050-18, 023234-18, 025241-18, 029925-18, 031330-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

IVY LAM (646), PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 23, 24, 25, 29, 30, 31, February 1, 4, 5, 7, 8, 11, 12, 13, and 14, 2019.

The following Critical Incident System (CIS) intakes were inspected:
- Log #003210-18 related to acute respiratory infection outbreaks declared by public health.
- Logs #023234-28, #029925-18, and #031330-18 related to falls with injury.
- Logs #013006-18, and #016660-18 related to resident to resident abuse.
- Log #025241-18 related to staff to resident abuse.
- Log #027050-17 related to resident to resident sexual abuse.

The following follow-up intake was inspected concurrently with this CIS inspection: Log #021050-18 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOC), Program Support Nurse (PSN), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Personal Support Workers (PSW), Behavioural Supports Ontario (BSO) PSW, BSO RPN, Facilities Supervisor, residents, substitute decision makers (SDM) and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the home's infection prevention and control practices, staff and resident interactions and the provision of care, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2018_420643_0010	646

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan has not been effective, different approaches had been considered in the revision of the plan of care.

This inspection was initiated to inspect on an incident reported to the Ministry of Health and Long-Term Care (MOHLTC) that resident #002 had an unwitnessed fall on an identified date in an identified common area and was transferred to hospital. Resident #002 returned to the home on a subsequent identified date, then returned to hospital four days later with a specified diagnosis. Resident #002 passed away seven days later in the hospital.

Review of the resident's falls history in the progress notes on PointClickCare (PCC), in the last quarter prior to the resident's passing away indicated resident #002 had fallen:
• Three times in the first identified month,
• Three times in the second identified month, and
• Five times in the third identified month.

Review of resident #002's initial post fall assessment for the first fall in the first identified month showed that the resident sustained an identified injury from the fall and was sent to the hospital. Review of the Post Fall Huddle section on the initial post fall assessment indicated that the resident was in the hospital and strategies would be implemented at a later date.

Review of the physiotherapist (PT) referrals and progress notes showed that a PT referral was not made for resident #002's fall mentioned above. Interview with the PT indicated that they did not receive a referral for resident #002's abovementioned fall.

Review of the resident's progress notes indicated the resident returned from hospital the day after the abovementioned fall. No new falls prevention interventions or approaches were documented. Review of resident #002's progress notes showed that resident #002 had another fall ten days after returning to the home, and a new identified falls prevention intervention was included in the written plan of care.

Interview with Supervisor of Care (SOC) #106 and the Director of Care (DOC) indicated that the resident should have been referred to the PT if the resident had a fall with injury as per the home's policy, and the resident was not referred. New strategies or different

approaches were not considered in the revision of the plan of care for resident #002. [s. 6. (11) (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 that if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 has 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 were documented.

This inspection was initiated to inspect on an incident reported to the MOHLTC that resident #002 had an unwitnessed fall on an identified date in an identified common area, sustained an injury on an identified area of the resident's body, and was transferred to hospital. Resident #002 returned to home, then was sent again to the hospital four days later with a specified diagnosis, and passed away seven days later in the hospital.

Review of the resident's fall history in the progress notes on PCC in the last month prior to the resident passing away, indicated that resident #002 had fallen on five identified

dates.

Review of referrals to the PT showed that the resident was assessed by the PT on an identified date in the abovementioned month, and an identified assistive mobility device was recommended for the resident.

Review of resident's post fall assessment's post fall huddle for a subsequent fall included to have staff walk with resident when they are using the abovementioned assistive mobility device to ambulate.

Review of the Occupational Therapy Referral note at a later identified date made reference to the PT and indicated that the PT reported the resident can ambulate with assistance with the abovementioned assistive mobility device.

Review of the PT note on a later identified date indicated staff are to walk with resident #002 using the identified assistive mobility device with an identified level of staff assistance.

Review of resident #002's care plan history did not indicate the use of the abovementioned assistive mobility device as an intervention for the resident. Review of resident #002's Point of Care (POC) Documentation Survey Report v2 did not include documentation of resident's #002's response to the use of the identified assistive mobility device.

Interview with the PT indicated that the identified assistive mobility device was used for resident #002 as part of their falls prevention interventions. The PT further indicated that they had communicated the recommendation to the registered staff.

Interview with RPNs #101 and #102 who worked with resident #002 in the abovementioned month indicated that the registered staff should have documented the falls prevention intervention in the resident's written care plan.

Interview with SOC #106 and the DOC indicated that the documentation was not completed related to resident #002's use of the identified assistive mobility device as a falls prevention intervention and it should have been 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 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, to be implemented voluntarily.

WN #3: 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 were 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.

A CIS report was submitted to the MOHLTC on an identified date related to an alleged identified abuse of resident #014 by resident #013. Review of the CIS showed that on an identified date, resident #013 was found by resident #014's caregiver in an identified position by resident #014 in resident #014's room. Resident #013 was seen engaged in an inappropriate behavior and touching identified areas of resident #014's body. Resident #014 was heard by the private caregiver to voice out identified refusal of resident #013's actions. Resident #014's identified clothing was observed by the private caregiver to be

partially removed. Resident #014's private caregiver removed resident #013 from resident #014 and called for help. Resident #013 was immediately separated from resident #014, and an identified method of monitoring was initiated.

Record review of the homes investigation notes indicated that resident #013 was seen entering other residents' rooms that were next to theirs to use their bathroom, stating that it was their home or they were looking for their spouse. Further review of the investigation showed that staff had to redirect resident #013 to leave the other residents' rooms.

Record review of progress notes on an identified date indicated that resident #013 was seen touching an identified area of a female resident's body. The resident was separated from the female resident, and resident #013 was redirected to their room. Further review of progress notes did not include communication to the Behavioural Supports Ontario (BSO) team, SOC, physician or any assessment for interventions related to resident #013's inappropriate behavior towards female residents.

Review of resident #013's care plan for two identified months indicated there were no identified interventions for resident #013's wandering behaviour into other resident rooms related to looking for spouse or for resident #013's inappropriate behaviours toward female residents.

In an interview with PSW #115, they stated resident #013 was known for entering the room of two female residents' that was beside their room. Resident #013 had to be redirected out of the room. PSW #115 stated they spoke with the nursing staff to move resident #013 to a different room to prevent the resident from entering the room. They further stated that resident #013 mostly had identified inappropriate behaviours towards staff and other female residents while they ambulated the halls.

In an interview with RN #117, they stated resident #013 would walk the hallways and display inappropriate behaviours toward female residents and staff. When resident #013 was admitted to the home, the resident was known to look for their spouse and was wandering into other resident rooms. RN #117 stated that the SOC and BSO team would have been informed of the behaviour and the care plan should be updated with interventions.

RN #117 could not recall if the BSO team was informed of the wandering behaviour or the incident where resident #013 exhibited inappropriate behaviours toward another

resident.

In an interview with former BSO RPN #114, they stated that if residents were exhibiting identified behaviours or touching other female residents, a referral should have been made to the BSO team for assessment. BSO RPN #114 could not recall if there was a referral made prior to the incident on the identified date related to these behaviours. BSO RPN #114 acknowledged there should have been more follow up or more interventions for resident #013's behaviours.

In an interview with the DOC, they stated if resident #013 was exhibiting the abovementioned behaviours, the SOC and BSO team should have been informed, and completed the appropriate assessments. DOC stated that staff were redirecting resident #013 out of other resident rooms and accompanying the resident to their room; however, a greater focus was placed on those interventions after the incident. [s. 54. (a)]

2. A CIS report was submitted to the MOHLTC on an identified date related to resident #012 sustaining an identified injury on an identified area of their body after being pushed by resident #011.

Review of the CIS report showed that on an identified date, resident #012 was being assisted by PSW #103 after an identified meal, with removal of their clothing protector. Resident #012 suddenly stood up with an identified personal item in hand and attempted to hit the PSW. Resident #011 who was seated at a table across from resident #012, got up and pushed resident #012 causing the resident to fall. Upon assessment, resident #012 was noted to have an identified injury to an identified part of their body and appeared to have pain in other identified part of their body. Resident #012 was subsequently sent to hospital and was diagnosed with an identified injury. Resident #012 returned to the home on a later identified date, with orders for identified treatment for the injury.

Review of resident #011's care plan indicated identified interventions for the resident's identified responsive behaviours in place prior to the date of the abovementioned incident.

Record review of progress notes indicate on another identified date, resident #011 was found arguing with another resident and required staff to intervene. Further review of

progress notes showed that on a subsequent identified date, resident #011 was found on the floor, engaged in behaviours of physical aggression with another resident after an argument with the resident. Staff separated both residents, however resident #011 resisted redirection and was monitored closely.

Review of resident #011's assessments in PCC did not reveal any referrals to the BSO team related to resident #011's behaviours during the abovementioned identified period. Further review of progress notes did not include communication to the SOC, physician or completion of any assessment for interventions related to resident #011's behaviours.

In an interview with PSW #103, they stated that resident #011 would get up and try to challenge people, and would try to get up and demonstrate responsive behaviours toward other residents if they didn't listen to what they were saying. They further stated that they would have to separate the residents and redirect resident #011 with one to one attention, or redirect the resident to engage in other identified activities as an intervention. They further stated that after the incident reported on the CIS, they asked resident #011 why they had demonstrated the aggressive behavior toward resident #012, and the resident stated that they were trying to protect the PSW.

In an interview with RN #101, they stated resident #011 had identified responsive behaviours and occasionally displayed verbal aggression towards other residents. They further stated that some interventions for those responsive behaviours would be to take resident #011 aside, speak with them, and make the resident feel important. RN #101 stated they could not recall what interventions were in place for the incidents between resident #011 and the other resident on the two abovementioned identified dates. They stated that a referral should have been made to the BSO team to complete an assessment, initiate dementia observation system (DOS) and interventions should have been put in place specific to those behaviours.

In an interview with the DOC, they stated that if residents were exhibiting responsive behaviours towards other residents, the expectation would be for staff to intervene when appropriate, communicate with other staff about the responsive behaviours and have the appropriate interventions care planned. They further stated that for resident #011, BSO team should have been informed to initiate an assessment of the resident to resident interactions, interventions should have been discussed and care planned. [s. 54. (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 to 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, to be implemented voluntarily.

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.