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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2019	2019_631210_0009	007404-19	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

SLAVICA VUCKO (210)

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): May 27, 31, June 3, 4, and 5, 2019.

During the course of the inspection the following Critical Incident System (CIS) report was inspected:
-Intake #007404-19

During the course of the inspection, the inspector(s) spoke with Director of Care, Supervisors of Care (SOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Physiotherapist (PT) and Resident Assessment Instrument (RAI) Coordinator.

During the course of the inspection, the inspector(s) reviewed the health record for resident #001, #002, #003, #004 and #005, reviewed policies and procedures for falls prevention and personal support services program.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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

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 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 :

The license has failed to ensure staff used safe transferring and positioning devices or techniques when assisting residents.

1. A Critical Incident System (CIS) report was submitted to Ministry of Health and Long

Term Care (MOHLTC) about resident #001 who was taken to hospital on a specified date for a change in health condition and resulted in a significant change in the resident's health status as injury was identified during the hospitalisation.

A review of the CIS indicated resident #001 had a fall in the morning of a specified date, onto a floor mat, from a low bed, in their room. The resident was assessed by registered nurse RN #101 after the fall and no injuries were identified. During the day shift on the same day, the resident presented with specific symptoms and was transferred to hospital. On the next day, the resident was diagnosed with body injury and was operated. They returned to the home 10 days later and soon after the resident passed away.

A review of resident #001's clinical record indicated the resident was admitted in the home on a specified date, using a walker for mobility. The resident was at high risk for falls. Soon after the admission the resident had a fall and sustained an injury. Since this fall the resident used a wheelchair for locomotion.

A review of resident #001's written plan of care indicated the resident required transfer with an identified mechanical Lift since a specified date, and total assistance by two staff.

A review of the Physiotherapist (PT) assessment from a specified date, indicated the resident was at a high risk for falls, non-ambulatory and required transfer with mechanical lift. They were not able to stand independently.

A review of the point of care (POC) documentation for the month before the injury including the flow sheets for transfer indicated the resident was transferred two times a day from which approximately 30% with mechanical lift, and the rest times without a mechanical lift but with a transfer aid such as cane, walker, bedrail, grab bar or transfer belt.

Interview with PSW #108 indicated the staff are expected to document if a resident is transferred with a mechanical lift. They documented that they did not use the mechanical lift to transfer resident #001 but a transfer aid (cane, walker, bedrail, grab bar or transfer belt).

A review of the flow sheets indicated PSW #107 transferred the resident certain number of times in a particular month and never used a mechanical lift but a transfer aid (cane, walker, bedrail, grab bar or transfer belt). During interview, PSW #107 indicated that according to the resident #001's care plan they have to be transferred by mechanical lift

and confirmed that they transferred resident #001without mechanical lift, and sometimes with two or one person. PSW #107 explained that they did not use the mechanical lift because the resident tried to hold onto items in the room and tried to participate in the transfer.

Interviews with PSWs #103, and #108 indicated that the transfer should be provided according to the written plan of care, and if the current method of transfer is not safe, they should upgrade the transfer (from one to two person, from two person to Sit to Stand lift, from Sit to Stand lift to total hoyer lift) but not to downgrade. Interview with PSW #103 indicated they transferred the resident with the incorrect type of lift and they documented accordingly.

During interview, PSW #107 was not able to explain that changing the transfer method from mechanical lift to two or one person meant a transfer downgrade.

Interviews with the DOC, SOC #102 and PT #106 indicated that the expectation is for the staff to follow the written plan of care for transfer. They acknowledged that resident #001 was not transferred safely.

2. Resident #004 who required transfer with a mechanical lift was inspected.

Interview with PSW #105 indicated resident #004 required total assistance during transfers using the specified mechanical lift. The documentation for the dates when they worked confirmed the same.

A review of the PT assessments and interview with the PT confirmed resident #004 to be transferred with mechanical lift-total hoyer lift since a specified date, according to the transfer assessment.
A review of resident #004's written plan of care indicated the resident required a specified mechanical lift type for transfer on and off the toilet. At times resident #004 can manage two staff side by side pivot for transfers. Transferring from one position to another was extensive - total assist by two staff (pivot transfer).

Interview with PSW #109 indicated they transfer resident #004 without using a mechanical lift and resident is able to stand and hold the grab bar while toileting. Further, PSW #109 indicated that staff are supposed to follow the written plan of care, and they believed they were providing proper care. The documentation indicated that during the three times when they provided care in a particular month they did not use a mechanical

lift.

A review of resident #004's flow sheets for transfer for a particular month indicated the resident was transferred two times a day from which approximately 30% without the use of a mechanical lift but a transfer aid (cane, walker, bedrail, grab bar or transfer belt).

Interview with the DOC, SOC #102 and PT #106 indicated that the expectation is for the staff to follow the written plan of care for transfer. They acknowledged that because the written plan of care was not updated as per the PT's assessment, resident #004 was not transferred safely.

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 7th day of June, 2019

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

Original report signed by the inspector.