Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue


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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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jul 12, Sep 2, 20, ~~Oct 11~~ Nov., 2011 | 2011_026147_0010 | Complaint |

**Licensee/Titulaire de permis**

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

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

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

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

LALEH NEWELL (147)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Director of Care, Nurse Supervisor, registered staff, resident and family.**

**During the course of the inspection, the inspector(s) Reviewed the resident's clinical chart, observed care and home's policy and procedure regarding Skin and Wound Care and Prevention of Abuse and Neglect also reviewed.**
**H-001358-11**

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

**Dignity, Choice and Privacy**

**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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. 6. Plan of care**

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

**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;**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee did not revise the plan of care with changes in the resident's care needs. An identified resident's Power of Attorney, purchased a new piece of equipment for the resident and delivered it to the home. The staff were advised regarding the delivery of the equipment. However the plan of care for the resident did not include information related to the new equipment and the Power of Attorney's wishes.

***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 resident's plan of care is reviewed and revised when the resident's care needs have changed or care set out in the plan is no longer necessary, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations;**
**(b) appropriate action is taken in response to every such incident; and**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. An identified resident sustained a bruise which was reported to the registered staff by the resident's daughter. According to interview with the resident's daughter this allegation of abuse related to the bruises were reported to the home. However the home failed to immediately investigate the incident when it was reported to the licensee by the family to determine the cause of the incident.

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.**

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**Findings/Faits saillants :**

1. According to interview conducted with the resident's daughter the staff are inconsistent with the times as to when the resident is put to bed in the evenings. The home failed to ensure the resident's desired bedtime and rest routine is supported and individualized by the staff to promote the residents comfort.

**Issued on this 20th day of September, 2011**

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