Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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 14, 2021	2021_754764_0011	024470-20, 024961-20, 006715-21, 006815-21, 007098-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor 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

NAZILA AFGHANI (764)

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 17, 18, 19, 20, 25, 26 and 27, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #006715-21, Log #024961-21, Log #007098-21, Log #006815 were related to falls prevention and management; and Log #024470-20 was related to medication.

During the course of the inspection, the inspector(s) spoke with Administrator, Supervisor of Cares (SOCs), Program Support Nurse, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents "and conducted observations of the Infection Prevention and Control (IPAC) practices in the home".

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining

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)**

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Resident's care plan, indicated that the call bell was to be in reach at all times by resident.

Review of resident's clinical records, revealed that resident needed physical assist for locomotion in their room.

Inspector's observation with PSW #110 on identified date and time, revealed that the call bell was on the bed while resident was sitting in their wheelchair within a 1.5 meters distance.

PSW #110 indicated that they were aware of care plan directions but they failed to comply.

RPN #111, stated that staff should follow the care plan directions and place the call bell near the resident's hand.

Sources: Resident 's care plan, Inspector #764's observation, interview with PSW #110 and RPN #111.

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 call bell is within reach as specified in the plan of care for residents, to be implemented voluntarily.

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 has failed to ensure that staff used safe transferring techniques when assisting residents #002 and #004.

Review of a Critical Incident System (CIS) report and progress notes showed resident #002 had a fall in spring, 2021, when two PSWs were using a specified mechanical device for transfer. Due to an unexpected resident's movement, they fell in the space between the wheelchair and bed, which caused an injury and were transferred to hospital.

Resident #002's care plan, indicated staff were to be ensured that the wheelchair was positioned as close to bed as possible to eliminate the space gaps/traps and the wheelchair and bed to be appropriately aligned at the same height to facilitate a smooth transfer.

On specified time and date, the inspector observed PSWs #110 and #112 transferred resident #002 from wheelchair to bed, using a specified mechanical device, when wheelchair was about one meter far from the bed in the middle of the room and bed level was almost 25 centimeters (cm) higher than wheelchair.

PSW #112 indicated that they were aware of resident #002's care plan directions and techniques for a safe transfer but they failed to do it.

On the other specified date and time, the inspector observed PSWs #116 and #117 transferred resident #004 from bed to wheelchair, using the specified mechanical device, when the bed level was about 25 cm higher than wheelchair.

PSW #116 stated that for a safe transfer, the bed and the wheelchair should be at the same level but they failed to do it.

SOC #101 and #115 were made aware of the observations, they noted staff should follow the directions and techniques for a safe transfer. They added staff education and monitoring needed to be continued.

Sources: CIS report, residents' #002 and #004 clinical records, Inspector's observation and interview with PSWs #112, #116, SOC #101 and #115. [s. 36.]

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 use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint assessment included the circumstances precipitating the application of the restraint.

Review of policy of minimizing restraint use and the use of Personal Assistant Services Devices (PASD) program, Region of Peel Long Term Care Centres with the last revision on March 27, 2017, indicated that the resident's behavior and other factors that led to the application of the physical restraint should be documented in the resident's electronic health record.

Review of resident #002's clinical documentation revealed that a physician order was in place since January, to use the specified restraint.

Review of two Nursing - PASD/Restraint Assessments for resident #002, , in Point Click Care (PCC) showed the circumstances precipitating the application of the specified restraint was not documented.

RPN #111 was aware that specified restraint was used as physical restraint for resident #002 and agreed that the restraint assessment was not included the circumstances precipitating the application of it.

SOC #115 stated that the reason for using the restraint should be recorded for each time of assessment.

SOC #101 after review of resident #002's restraint assessment, stated the home should work on a plan to review and educate the staff regarding restraint assessments.

Sources: Policy of minimizing restraint use and the use of Personal Assistant Services Devices (PASD) program , Region of Peel Long Term Care Centres,resident #002's clinical records, interview with RPN #111, SOC #115 and #101. [s. 110. (7) 1.]

2. The licensee has failed to ensure that the documentation included the alternatives that were considered and the reason if those alternatives were inappropriate.

Review of policy of minimizing restraint use and the use of Personal Assistant Services Devices (PASD) program, Region of Peel Long Term Care Centres with last revision on March 27, 2017, indicated when a resident is restrained the following shall be identified and documented in the resident's electronic health record: the alternatives considered and the reason that the alternatives were found to be ineffective.

Review of resident #002's clinical documentation revealed that a physician order was in place since January, to use the specified restraint.

Review of two Nursing - PASD/Restraint Assessments for resident #002, in Point Click Care (PCC) showed the considered alternatives to physical restraint and the reason of its inappropriateness were not documented.

RPN #111 was aware that restraints were used as physical restraints for resident #002

and agreed that the restraint assessment was not included with the alternatives and the reason of its ineffectiveness before applying.

Review of Nursing - PASD/Restraint Assessment for resident #005 on identified date, in Point Click Care (PCC) showed the considered alternatives to physical restraint and the reason of its ineffectiveness were not documented.

SOC #115 stated that staff nurses should document all the considered possible alternatives before applying the restraint.They added restraint should be considered as the last option.

SOC #101 after review of residents' #002 and #005 restraint assessments, stated the home should work on a plan to review and educate the staff regarding restraint assessments.

Sources: Policy of minimizing restraint use and the use of Personal Assistant Services Devices (PASD) program , Region of Peel Long Term Care Centres,resident #002 and #005 clinical records, interview with RPN #111, SOC #115 and #101. [s. 110. (7) 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 to ensure the requirements relating to restraining by a physical device, to be implemented voluntarily.

Issued on this 15th day of June, 2021

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

Original report signed by the inspector.