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

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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
Mar 30, 2022	2022_955698_0003	018110-21	Complaint

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

ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 17, 18, and 21-24, 2022.

The following intake was completed in this complaint inspection:
Log # 018110-21 related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Supervisor of Care (SOC), Registered Nurse (RN), Infection Prevention and Control (IPAC) lead, Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector conducted observations of resident, staff and resident interactions and the provision of care; conducted review of resident health records, the home's internal investigation notes, complaint records, policies and procedures and conducted observations of the IPAC practices in the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to immediately report an allegation of abuse of a resident to the Director.

In accordance with s. 24 (1) 2 of the Long-Term Care Homes Act, pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with s. 24 (1).

A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding allegations of sexual abuse of a resident by staff.

The home's policy titled, "Prevention, Reporting and Elimination of Abuse/Neglect", #LTC1-05.01 revised October 14, 2020, states that any person who has witnessed or has reasonable grounds to suspect abuse or neglect of a resident must immediately make a report to the home’s Administrator/designate and Ministry of Long-Term Care (MLTC).

A resident reported an incident of alleged abuse by a Personal Support Worker (PSW). The PSW reported the allegations to an RN, who documented the information and failed to report it to their supervisor and the MLTC. The RN did not report the abuse allegations to their supervisor due to the inaccuracy of the resident’s allegation and did not think it was necessary at the time.

There were no Critical Incident System (CIS) reports submitted to the Director relating to this complaint.

The Director of Care (DOC) was not aware of the allegations and expected staff to comply with the home’s policy, and report all witnessed or suspected allegations of abuse immediately to their supervisor and/or the Ministry.

Sources: resident electronic records and paper chart, complaints binder, Prevention, Reporting and Elimination of Abuse/Neglect Policy #LTC1-05.01 with dated revision October 14, 2020, interview with resident and staff. [s. 24. (1) 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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

Issued on this 1st day of April, 2022

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

Original report signed by the inspector.