Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 10, 2023	
Inspection Number: 2022-1613-0001	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of Peel	
Long Term Care Home and City: Malton Village Long Term Care Centre, Mississauga	
Lead Inspector Ramesh Purushothaman (741150)	**Inspector Digital Signature** Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.01.16 12:04:53 -05'00'
Additional Inspector(s) Matthew Chiu (565)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6 - 9, 12, 13, 2022 on-site
December 15, 16, 19 - 23, 28 - 30, 2022 off-site

The following intake(s) were inspected:

- Intake: #00001599, #00002997, #00003203, #00004174, #00005465, #00007015, #00007098, #00008721 related to falls prevention and management.
- Intake: #00003745 Improper transfer resulting in an injury.
- Intake: #00012007 related to allegation of abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised anytime when the resident's care needs changed.

Rationale and Summary
At the time of inspection, resident #002 required a certain type of transfers. During interviews with Personal Support Workers (PSW), they indicated that they were providing a different level of assistance for transfers of resident #002 on a regular basis, even though the care plan stated that they required a certain level of assistance at that time. PSW #102, #112 had brought it up to the registered staff requesting a transfer assessment at that time.

During an interview, the physiotherapist (PT), stated that they completed a transfer assessment as per the referral initiated by the registered staff, and the registered staff were responsible for updating the care plan. The care plan was not reflective of the PT recommendation until later that month.

Sources: Resident #002's progress notes, plan of care in Point Click Care (PCC), Management investigation records, CIS report, Interviews with PSW #102, #112, PT #117 and interim DOC #107.

Date remedied: Dec 13, 2022

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WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure resident #002's right to be treated with courtesy and respect that fully recognizes inherent dignity, worth and individuality was respected by PSW #102.

Rationale and Summary:
Resident #002's daughter/the Power of Attorney (POA) had alleged that PSW #102 had provided rough care and made a complaint to the home.

During interview with the POA, they stated that they had recorded video footage of the incidents from the cameras that they had installed in the resident's room and bathroom.

Video footage on a specified date, showed resident #002 assisted by PSW #102 with another staff causing discomfort to the resident during the assistance.

Video footage from another specified date showed PSW #102 pushing resident #002's body part down forcibly.

In a video footage from a particular date, PSW #102 was noted to remove resident #002's personal items and provided care without communicating what was being done. The same PSW made disrespectful comments during care.

A video footage from another date, showed PSW #102 made an inappropriate gesture and a discourteous comment when the resident was calm.

With the multiple video footages reviewed, it was evident that the resident was not communicated with while care was being provided. Staff did not allow the resident to express what they wanted during care. Non-courteous comments were made by the staff during the care, which lowered the resident's respect, dignity, and self-worth.

Sources: CIS report, review of video files shared by resident #002's POA/daughter, home's investigation records, resident #002's progress notes and interview with PSW #105, #112, registered staff #106, #115, interim DOC #107, daughter.

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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out the infection prevention and control (IPAC) audits directive that applied to the long-term care home.

Rationale and Summary:
The Minister's Directive, COVID-19 response measures for long-term care homes directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits every two weeks unless in an outbreak. When a long-term care home is in an outbreak, the IPAC audits must be completed weekly. At minimum, the audits must include Public Health Ontario's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes".

The home did not complete the required IPAC audits every two weeks when they were not in outbreak and weekly when they were in outbreak during the period from October to November 2022.

Sources: Critical Incident System report, IPAC audit records; interviews with PSN/IPAC Lead #111 and interim DOC #107.

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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 1.

The licensee has failed to ensure that the Director was immediately informed of an improper care of a resident that resulted in a harm to the resident.

Rationale and Summary

A Critical Incident System (CIS) reported that resident #001 sustained an injury as a result of staff providing improper care.

Record review of resident #001's care plan indicated that the resident required a certain type of transfer assistance.

A review of resident #001's progress notes identified that they had sustained an injury when PSW #102 transferred them without following the care plan.

During interview with the interim Director of Care (DOC) #107, they could not state a reason why this was not reported on time.

Failure of the home to notify the Director immediately about improper or incompetent treatment or care of a resident prevented the Director from responding as required.

Sources: Resident #001's progress notes, CIS report # M618-000019-21, complaint investigation notes provided by the interim DOC #107

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WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee has failed to comply with their staff using a safe transferring technique when assisting a resident.

Rationale and Summary
On a specified date, resident #001 was provided care by PSW #102. After the task was complete, PSW #102 noted that the resident had sustained an injury and the PSW called the registered nurse for help.

Registered staff #103 noted that the resident had sustained an injury.

Interview with PSW #102 confirmed that they did not verify the care plan and provided a wrong level of assistance during the care. Registered staff #103, interim DOC #107, PT staff #117 confirmed that the technique was unsafe and caused injury and pain to the resident.

As a result of the injury sustained by the resident from the improper care, there was moderate impact to the resident.

Sources: Resident #001's progress notes, plan of care in Point Click Care (PCC), Management investigation records, CIS report, Interviews with PSW #102, RPN #103, PT staff #117 and Interim DOC #107.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard for long-term care home issued, April 2022, by the Director was implemented in accordance with the standard:

-10.4 (h), stated support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting. Specifically, the licensee failed to ensure that the staff supported residents to perform hand hygiene prior to receiving their meals.

Rationale and Summary:
On a specified date, during lunch time in Victory House, observation and staff interviews indicated that a PSW assisted residents, at their tables in the dining room, to perform hand hygiene using alcohol-based hand rub. After they finished, four residents entered the dining room by themselves at different times. They sat at their tables, and they were served with their meals. They were not supported by the staff to perform hand hygiene before their meals.

The Program Support Nurse (PSN) who was the home's infection prevention and control (IPAC) program

lead stated that all staff in the dining room should have supported residents for their hand hygiene before and after their meals. Failure to support residents to perform hand hygiene prior to serving their meals increased the risk of transmission of infection.

Sources: Lunch observation; interviews with Activation Therapist #110 and PSN/IPAC Lead #111.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the home's IPAC program.

Rationale and Summary:
(i) A signage was posted at the TV lounge on Victory House that stating the maximum occupancy of the lounge was six persons. Multiple observations at the TV lounge indicated that there were more residents than the maximum occupancy.

Staff interviews indicated some of the unit staff did not know that they must follow the home's IPAC direction to ensure that no more than six persons occupy the lounge at the same time.

The IPAC lead and the interim DOC stated their IPAC practice implemented the maximum occupancies in different areas of the home, and they posted the numbers in the areas. In the TV lounge, it was expected to be no more than six persons as posted, and staff should have implemented it, but they did not.

Staff failed to participate in the implementation of the IPAC practice caused a risk of transmission of infection.

Sources: Observations; signage posted at the TV lounge; interviews with PSW #109, PSN/IPAC Lead #111, interim DOC #107 and staff.

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(ii) Resident #002's daughter shared video footages relating to care provided for their mother by a PSW #102.

Video footage on a certain date, showed PSW staff #102, wearing the face mask under their chin exposing their nose and mouth.

Video footage from another date, showed PSW #102, wearing a N95 mask improperly by not covering their nose.

Video footage from another date, showed PSW #102, not wearing full Personal Protective Equipment (PPE) as required during the time when the home was in an COVID outbreak.

Video footage from two separate dates, showed PSW #102, wearing the face mask under their chin exposing their nose and mouth.

Review of LTCH's policy #LTC8-03.08, section: Routine practices and additional precautions, on page 3 of 4 stated that proper use of PPE should be included as additional precautions.

Interview with Infection Prevention and Control (IPAC) lead of the home confirmed that the staff did not follow appropriate IPAC practices.

Failure to ensure staff are wearing PPE properly when providing care for the resident increased the risk of transmission of infection.

Sources: Review of video footage sent by resident #002's family, review of LTCH's IPAC policy on routine practices, Interview with IPAC lead.

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