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
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Original Public Report

Report Issue Date: August 18, 2023
Inspection Number: 2023-1613-0003
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of Peel
Long Term Care Home and City: Malton Village Long Term Care Centre, Mississauga

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.09.05 21:19:37 -04'00'

Additional Inspector(s) Cindy Ma (000711)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31 and August 1-3, 2023

The following intake(s) were inspected:

-Intake: #00086765 [Critical Incident System (CIS) #M618-000019-23] related to improper transfer
-Intake: #00093116 was a Complaint related to air conditioning

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

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)
O. Reg. 246/22, s. 23 (2) (a)

The licensee has failed to ensure that a resident was assessed to identify specific risk factors that may lead to heat-related illness.

Rationale and Summary

The home's written heat-related illness prevention and management plan directed staff to complete the heat risk assessment tool and update the plan of care with the risk level goals and interventions to be implemented based on the assessed needs of the residents. A heat risk assessment was not completed for a resident. The resident's written plan of care contained interventions related to heat-related illness. The staff acknowledged that a heat risk assessment was not completed for the resident and was expected to be completed.

After being notified, a heat risk assessment was completed on August 03, 2023, and the resident was deemed to be at low risk.

There was a low risk to the resident when the heat risk assessment tool was not completed.

Sources: Heat Related Illness Prevention and Management Program policy, resident's clinical records and interview with the staff member.

[739633]

Date Remedy Implemented: August 3, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident's wounds.

Rationale and Summary

The resident sustained two large lacerations and was referred to a wound care specialist.

The wound care specialist completed their consultation and documented their treatment plan in home's electronic health record system. Staff were unaware of the treatment plan and failed to follow up with the wound care specialist. As a result, the wound care treatment plan was not transcribed by the home.

Staff members acknowledged that the home should have followed up with the wound care specialist in the assessment of the resident and confirmed the staff failed to collaborate with the wound care specialist in the assessment of the resident.

The failure of staff to collaborate with the wound care specialist placed the resident at risk of harm when the wound care specialist's treatment plan was not carried out.

Sources: Resident's clinical record; CIS report; and interviews with staff members.

[000711]

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.

The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Rationale and Summary

The home's Indoor Air Temperature and Humidity Checks for two months showed that temperature readings were not documented in two resident bedrooms in different parts of the home.

The staff members verified and acknowledged that the temperature was not measured and recorded in two resident rooms in different parts of the home as required.

Residents were at risk of developing heat-related illnesses when the temperature was not monitored in residents' rooms.

Sources: Indoor Air Temperature and Humidity Checks, Home's policy: Heat Related Illness Prevention and Management Program, interviews with staff members.

[739633]

WRITTEN NOTIFICATION: Air temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.

The licensee has failed to ensure that air the temperature was measured and documented in writing in one resident common area on every floor of the home.

Rationale and Summary

The home's Indoor Air Temperature and Humidity Checks for two months showed that the temperature readings of one resident common area on each of the home's three floors were not documented.

The staff members verified and acknowledged that the temperature was not measured and documented in the common areas of each home floor as required.

Residents were at risk of developing heat-related illnesses when the temperature was not monitored in residents' common areas.

Sources: Indoor Air Temperature and Humidity Checks, Home's policy: Heat Related Illness Prevention and Management Program, interviews with staff members.

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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. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques during a transfer of a resident.

Rationale and Summary

The resident required a specific level of assistance for transferring.

The resident sustained injuries during a transfer, was transferred to the hospital, and required interventions. The staff member confirmed that they did not completely remove a part of a resident's mobility device during the transfer.

The staff members acknowledged that the resident sustained the injury due to the mobility device's part not being removed fully during transfer, although it should be removed prior to any transfers to prevent injuries.

Failure to ensure the mobility device part was removed during transfer increased the resident's risk of sustaining an injury.

Sources: Resident's clinical record; CIS report home's investigation notes; and interviews with staff members.

[000711]