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

Original Public Report

Report Issue Date: 10/13/2023	
Inspection Number: 2023-1613-0004	
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 Trudy Rojas-Silva (000759)	**Inspector Digital Signature** Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2023.10.13 11:43:09 -04'00'
Additional Inspector(s) Nicole Ranger (189)	

INSPECTION SUMMARY

The inspection occurred on-site on the following date(s): September 7-8, 11-14, 2023
The inspection occurred off-site on the following date(s): September 15, 2023

The following intake(s) were inspected:

- Intake #00021621/Critcal Incident (CI) #M618-000011-23 was related to responsive behaviors;
- Intakes #00087111/CI #M618-000021-23, #00093206/CI #M618-000034-23, #00093387/CI #M618-000035-23, #00093514/CI #M618-000036-23, and #00094314/CI #M618-000038-23 were related to fall prevention and management;
- Intake #00095240/CI#M618-000045-23 and Complaint Intake #00095879 were related to medication management.

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The Licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

Resident was walking outside on the home's property when during the walk, they fell and sustained an injury. During the walk the resident stepped into a dip in the pavement while turning, as a result of the uneven surface the resident fell. The path taken was uneven and was a trip hazard to residents.

Failure to identify and address a safety hazard on the home's property resulted in an injury to resident.

Sources: Interview with relevant staff, Observation of path, Pictures of path
[000759]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that for a resident who demonstrated responsive behaviors, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Rationale and Summary

The resident displayed inappropriate behaviors towards other residents. There were multiple dates where the resident had inappropriate interactions with co-residents and with staff, some of which were physical in nature.

No evidence was identified during the inspection to indicate that assessments, reassessments, or referrals for the responsive behaviors exhibited by that same resident occurred between the specified dates.

The Behavioral Support Ontario (BSO) team and the Nurse Practitioner (NP) were not informed about the incidents. Staff were required to inform them of an incident, in order for a reassessment to be completed. Required staff did not complete a referral or notify the BSO team or the NP.

Staff are required to follow the home's responsive behavior clinical pathway and to notify BSO Team and NP if resident responsive behaviors are escalating.

Failure to reassess the resident's responsive behaviors may have impaired the staff's ability to deescalate the behaviors and prevent further incidents.

Sources: resident plan of care, progress notes, interview with relevant staff
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COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

(i) The plan of care for the resident dated July 2023, included interventions to prevent

responsive behaviors towards co-residents by having a staff member support the resident during a meal.

During meal services, resident had a history of displaying behaviors that caused altercations between residents. Early September 2023, this same resident had altercations with three other residents. Part of this resident's responsive behaviors interventions was to have a staff member present at meal service to assist the resident, however they were not present during the meal service for a few weeks prior to the inspection.

The staff member did not follow the resident's care plan.

Failure to follow the resident's care plan placed other residents at risk for altercations with this resident.

Sources: resident plan of care, progress notes, interview with relevant staff
[189]

(ii) The licensee failed to ensure that the fall prevention interventions set out in the plan of care were provided to the resident, as specified in the plan.

Rationale and Summary

Fall prevention interventions for resident included wearing hip protectors at all times and, a logo on their wheelchair and door to their room, advising others of their risk for falls.

Resident was observed without hip protectors and no logo was observed on their room door or wheelchair.

Failure to implement fall prevention strategies for the resident as outlined in their plan of care has placed the resident at an increased risk for falls and injury.

Sources: Interview with relevant staff, Resident care plan, Observation done on September 8 and 12, 2023.

[000759]

(iii) The licensee shall ensure that the care set out in the resident's plan of care is provided to the resident as specified in the plan.

Rationale and Summary

Resident fell and sustained an injury while walking with a staff member. Prior to that fall incident resident plan of care indicated they were high risk for falls and required limited assistance by one staff member for mobility, more specifically physical assistance with guiding and maneuvering.

The staff member did not provide assistance to the resident, as required within the care plan, when the resident fell and injured themselves. The staff member was standing in front of the resident without physically assisting them.

Staff's failure to comply with resident's plan of care placed the resident at risk of falling and injuring themselves.

Sources: staff member, Resident care plan
[000759]

This order must be complied with by November 30, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.