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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 15, 2024.

Inspection Number: 2024-1613-0002

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**
Trudy Rojas-Silva (000759)	Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2024.05.27 13:38:16 -04'00'

Additional Inspector(s)
Lisa Salonen Mackay (000761)
Adelfa Robles (723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25-26, 29-30, 2024, and May 1-3, 6-7, 2024.

The following intake(s) were inspected:

- Intake #00108903 was related to a complaint.
- Intakes #00107495-Critical Incident (CI) #M618-000002-24, and #00108080-CI #M618-000003-24 were related to improper/incompetent care.
- Intake #00108835-CI #M618-000006-24 was related to an outbreak.

- Intakes #00111627-CI #M618-000018-24, and #00113421-CI #M618-000021-24 were related to fall prevention and management.
- Intake #00113885-CI #M618-000022-24 was related to prevention of abuse and neglect.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure the resident's plan of care included the fall risk identification program's pictogram, in front of the resident's room and on their wheelchair.

Rationale and Summary

A resident had a fall on a specified date and sustained an injury. The care plan indicated the resident was at risk for falls but had no reference to the fall risk identification program, including a specific pictogram in front of their room and on their wheelchair.

Registered Practical Nurse (RPN) acknowledged the resident was at risk for falls, but that the fall risk identification program was not indicated in the resident's care plan, and it was observed the resident had no pictogram on their wheelchair.

The home's policy stated residents at high falls risk should have interventions or strategies included in resident's plan of care to reduce the risk of falls. The nursing department was responsible for posting a pictogram in front of the room and on the wheelchair.

Falls Lead acknowledged the resident was at risk for falls and should have had a pictogram on their wheelchair and in the care plan, to ensure all staff and visitors were aware and provided increased supervision for that resident.

Sources: resident's clinical record; Falls Prevention and Management Program policy; and interviews with RPN and other relevant staff.
[000761]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care is based on the preferences of that resident.

Rationale and Summary

A resident reported that they had specific preferences regarding their care so that they could be seated comfortably in their wheelchair or when in bed.

Personal Support Worker (PSW) acknowledged that the resident did have preferences related to care, however upon review of the resident's plan of care, the resident's care plan did not reflect those preferences.

Supervisor Of Care (SOC) acknowledged that the care plan was not updated with the resident's preferences for care, although it should have been, so that care could be provided to the resident based on their preferences.

Failure to develop a plan of care reflective of the resident's preferences of care, put them at risk of not receiving care as per their preferences.

Sources: Interviews with resident, SOC and other relevant staff, resident's plan of care.
[000759]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the resident's plan of care was provided as specified.

Rationale and Summary

The home submitted a CI report when the resident had a fall.

The resident's written plan of care indicated they required two staff assistance with personal care. The home's investigation notes revealed that only one staff member provided care to the resident at the time of the fall, and the PSW confirmed that they provided care alone to the resident.

Registered Nurse (RN) and SOC both stated that staff were expected to follow the residents' plan of care.

Failure to provide care to the resident as directed in their plan of care potentially contributed to the resident sustaining an injury as a result of a fall.

Sources: Resident's plan of care, CI report, home's investigation notes, interviews with PSW and other relevant staff.
[723]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure the resident transfer sling and wheelchair were reassessed for comfort, when the care set out in the plan had not been effective.

Rationale and Summary

A resident reported that they were uncomfortable when sitting in their wheelchair due to having to sit on their transfer sling.

As per Occupational Therapist (OT) and Physiotherapist (PT), it was unsafe to remove the transfer sling from underneath the resident when they were sitting in their wheelchair, and the transfer sling was designed to be sat on.

However, OT acknowledged that the resident's wheelchair was not assessed in combination with the transfer sling, despite multiple concerns found in documentation that the resident was asking staff to re-adjust their transfer sling when they were sitting on it.

The RPN acknowledged that the resident continued to complain of discomfort while sitting on their transfer sling and that there have been no new interventions to address the resident's discomfort.

SOC acknowledged that the resident's transfer sling should have been re-assessed for comfort, as the interventions in place were not effective.

Staff's failure to re-assess the transfer sling for comfort, placed the resident at risk for compromised quality of life.

Sources: Interviews with resident, OT and other relevant staff, and resident's clinical records.
[000759]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The Licensee has failed to immediately forward to the Director any written complaint that was received concerning the care of a resident, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary

There were two emails that were sent to the SOC on two separate occasions, regarding the resident's concerns with their care.

The home's reporting and managing complaints and recommendations policy stated, when there is a written complaint of dissatisfaction with the care of a resident, the supervisor will complete the home's LTC complaint form, with the complainant (as appropriate) ensuring the person provides as much detail as possible about the complaint, a copy along with the home's response, must be submitted immediately to Ministry of Long-term Care Critical Incident Reporting System.

The SOCs acknowledged that they did not follow the home's process for reporting and managing written complaints, when they received the emails regarding the resident and did not immediately forward them to the Director.

Failure to follow the home's policy when written complaints were received regarding the resident's concerns with their care, placed them at risk of their care concerns not being addressed by the home.

Sources: Interviews with SOC's, and the Reporting and Managing Complaints and Recommendations policy.
[000759]

WRITTEN NOTIFICATION: Resident Care and Support Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

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

Rationale Summary

On a specified date, the resident had a fall.

The resident's care plan stated they needed two-person extensive assistance with transferring. The home's investigation notes revealed that a PSW attempted a one-person transfer.

The RN, the SOC and, the Director of Care (DOC) confirmed the PSW attempted an unsafe transfer with the resident, using a mechanical lift.

The DOC acknowledged the unsafe transfer did not meet the home's expectations for safe care of the resident.

Failure to ensure safe transferring techniques increased the resident's risk of sustaining an injury.

Sources: Resident's clinical record; home's investigation notes; and interviews with RN and other relevant staff.
[000761]