Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 12, 13, 14, 19, 20, 21, 2011; Jan 3, 12, 13, 2012	2011_064167_0024	Critical Incident

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, 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

MARILYN TONE (167)

Inspection Summary/Résumé de l'Inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, the Unit Manager, the Social Worker, the Environmental Manager, staff working on the unit, the resident involved in this critical incident inspection H-002252-11.

During the course of the inspection, the inspector(s) reviewed the health file for the identified resident, reviewed the home's investigation notes into the incident, reviewed the home's policies and procedures related to missing residents, Hourly Wanderer's Checks and Responsive Behaviours.

An area of non-compliance related to Complaint Inspection H-001915-11 (conducted simultaneously with this Critical Incident Inspection) was issued on this Critical Incident Inspection Report.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The plan of care for resident #1 did not give clear direction to staff related to pain that they were experiencing.

a) Three personal support worker staff interviewed indicated that resident #1 does not like to be positioned on their side due to pain and that the resident is only to be positioned on their back or other side because of this.
Staff interviewed also indicated that the resident is comfortable unless they are being positioned or transferred and that staff need to be careful of the resident when positioning them.
The plan of care for the resident #1 did not identify interventions related to their inability to tolerate laying on their side or care to be taken with regards to during positioning or transfers.
2. The plan of care for resident #2 did not provide clear direction to staff who provide direct care to them.

a) The document that the home refers to as the care plan for resident #2 indicated that a number of interventions were in place to manage the resident's wandering behaviours.

b) The documentation related to a Team Meeting held indicated some changes to the previous interventions in place to manage the resident's wandering behaviours. This was confirmed through interviews with the Director of Care, Administrator, Social Worker and front line staff.

The document that the home refers to as the care plan for resident #2 did not include the changes to interventions that were put in place as a result of the Team Meeting even though all staff and managers interviewed were aware that this was part of the plan of care for resident # 2.
The plan of care for resident #2 contained conflicting information related to interventions to be in place to manage their wandering behaviours.

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 the plans of care for residents provide clear direction to staff providing care., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that actions taken with respect to a resident under a program, including interventions and resident responses to interventions were documented.
An identified resident eloped from the home (Resident #2).
The plan of care that was developed for resident #2 related to their wandering behaviour indicated that they were to have their whereabouts monitored every hour. These monitoring activities were to be documented on the form provided.
The home's policy (Hourly Wandering Checks LTC9-06.05) effective February 18, 2011 directs staff to document information related to residents who are at high risk for wandering and are to be monitored hourly on the appropriate hourly checklist.
Documentation on this form was incomplete and some of the documentation was inaccurate. When resident #2 eloped from the home, the documentation on the hourly checklist indicated that the resident was checked at 1400, 1600, 1700, 1800 and 1900. There was no documentation to indicate that the resident's whereabouts were checked between 1400 and 1600. The resident was seen walking outside 1506 and did not return to the home until 1920. Staff at the home would not have been able to check the identified resident's whereabouts as documented. A staff member interviewed did confirm that the identified resident was on the unit and wandering the hallways at 1430 on the day of the incident when she ended her shift.
It was noted that the home initiated every 15 minute behavioural monitoring after an incident of elopement involving resident #2. The flow record related to the every 15 minute monitoring was not consistently completed for the resident. It was noted that there was no documentation of 15 minute monitoring activities on a number of occasions on the records reviewed.

Staff did not complete documentation as required on the Hourly Checklists and the every 15 minute behavioural monitoring checklist.

Issued on this 14th day of February, 2012

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

Marilyn Lowe