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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 17, and 18, 2010	2010_141_9618_16Nov112901	Critical Incident H-01883

Licensee/Titulaire
The Regional Municipality of Peel
10 Peel Centre Drive, Suite A, 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(s)
Sharlee McNally, Compliance Inspector – Nursing #141

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection reported to the Hamilton Service Area Office October 5, 2010.

During the course of the inspection, the inspector spoke with: The Administrator, The Director of Care, the resident.

During the course of the inspection, the inspector: reviewed the resident's records, reviewed the home policy on prevention of abuse and neglect, and reviewed the home's investigation notes related to the alleged incident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect
Personal Support Services

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

WN – *LTC Homes Act, 2007,* O. Reg. 79/10, s.26(3): was issued under inspection report 2010_141_9618_16Nov105730, Log # H-01803 completed on November 17 and 18, 2010. The following action was taken VPC.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the *LTC Homes Act, 2007,* S.O 2007, c. 8, s.3(1)3
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 3. Every resident has the right not to be neglected by the licensee or staff.

Findings:

1. An identified resident was neglected in care by the home's staff related to activities of daily living, and transferring techniques.

Inspector ID #: 141

WN #2: The Licensee has failed to comply with the *LTC Homes Act, 2007,* S.O 2007, c. 8, 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.

Findings:

1. Care was not provided to an identified resident as specified in their written plan of care.

Inspector ID #: 141

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.36

Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. Nursing staff of the home did not provided safe transferring techniques for an identified resident.

Inspector ID #: 141

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
	[signature]
Title: Date:	Date of Report: (if different from date(s) of inspection). May 30, 2011