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: November 26, 2024

Inspection Number: 2024-1613-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Malton Village Long Term Care Centre, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5-8, 12-15, 18, 19, 2024

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00122635 - [CI: M618-000045-24] - Resident to resident sexual abuse
- Intake: #00124435 - [CI: M618-000051-24] - Injury of unknown cause
- Intake: #00125002 - [CI: M618-000054-24] - Staff to resident emotional abuse and neglect
- Intake: #00125644 - [CI: M618-000056-24] - Staff to resident emotional abuse and neglect
- Intake: #00125869 - [CI: M618-000057-24] - Fall prevention and management

The following complaint intake(s) were inspected:

- Intake: #00129286 - Improper care

The following intake(s) were completed in this inspection:

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- Intake: #00124112 [CI: M618-000049-24] and intake #00127182 [CI: M618-000061-24] - Fall prevention and management
- Intake: #00129293 [CI: M618-000064-24] - Improper care

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident's plan of care directed staff to keep them apart from a particular co-resident. Upon observation, both residents were closely interacting in a common

area. A Personal Support Worker (PSW) was unable to confirm how the intervention was implemented when staff were not present around the residents. A Supervisor of Care (SOC) stated that the language in the plan of care could have been clarified for staff to understand how to implement the intervention.

Failure to ensure clear directions to staff in the plan of care increased the risk to a resident's safety.

Sources: Observations of residents; a resident's plan of care; and interviews with a PSW and SOC.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that resident #002 was protected from sexual abuse by resident #003.

Section 2 (1) of the Ontario Regulation 246/22 defines sexual abuse as “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitements d’ordre sexuel”).

Rationale and Summary
A critical incident (CI) was submitted regarding sexual abuse of resident #002 by resident #003. On an identified date, a RPN discovered resident #003 and resident

#002 sitting next to each other, with resident #003 touching resident #002 inappropriately. The RPN asked resident #003 to stop and subsequently left the room to find another staff to assist with translation. Upon returning to the room, resident #003 was discovered touching resident #002 inappropriately again. Both residents were separated and assessed by staff.

The RPN stated that they should have separated the residents completely at the time of the incident. The SOC confirmed that resident #003 touched resident #002 inappropriately twice.

Failure to protect resident #002 from sexual abuse by resident #003 could result in harm to resident #002.

Sources: CI report #M618-000045-24; home's investigation notes; and interviews with a RPN and SOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A RPN discovered resident #003 inappropriately touching resident #002. The RPN did not immediately separate the residents and the behaviour occurred a second time.

Review of the home's policy, "Prevention, Reporting and Elimination of Abuse/Neglect (LTC1-05.01)" indicated that the RPN will immediately ensure the wellbeing and safety of the resident and separate or remove the alleged abuser/neglecter from the resident.

The RPN and SOC confirmed that resident #002 and resident #003 were not separated from one another, resulting in recurrence of sexual abuse.

Failure to comply with the home's zero tolerance of abuse and neglect resulted in resident #002 being sexually abused by resident #003.

Sources: CI report #M618-000045-24; "Prevention, Reporting and Elimination of Abuse/Neglect (LTC1-05.01)" policy, and interviews with a RPN and SOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented

related to improper use of Personal Protective Equipment (PPE).

The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 (f), that additional precautions were followed, including appropriate selection, application, removal, and disposal of PPE.

Rationale and Summary
A PSW was observed providing care inside a resident's room on contact precautions. A contact precautions sign was posted on the door indicating the specific PPE to be worn by staff. The PSW wore gloves but did not wear a gown.

The PSW confirmed that staff were expected to wear gown and gloves when providing care to a resident on contact precautions. The IPAC Lead stated that staff did not wear appropriate PPE when entering the resident's room, and there was an increased risk of spread of infection to other residents in the home.

Sources: Observations; and interviews with a PSW and IPAC Lead.