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

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Public Report

Report Issue Date: April 11, 2025
Inspection Number: 2025-1613-0003
Inspection Type: 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): April 1 - 4 and 7 - 11, 2025.

The following intake(s) were inspected:

- Intake: #00136951 / CI #M618-000004-25 and Intake: #00138427 / CI #M618-000008-25 were related to, resident to resident abuse.
- Intake: #00138789 / CI #M618-000009-25 was related to, staff to resident abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 that there was a written plan of care for a resident that set out, the planned use of an intervention for the resident.

During an observation, a specific intervention was noted. The planned use of this intervention was not documented in the resident's care plan. Registered Nurse (RN) and Supervisor of Care (SOC) both acknowledged that the intervention was not written in the resident's care plan.

The intervention was documented in the care plan the day after the observation was made.

Sources: Observation, review of the resident's care plan, and interview with the RN and SOC.

Date Remedy Implemented: April 3, 2025

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 protect a resident from abuse by another resident.

Ontario Regulation 246/22, s. 2 (1) (c) defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)".

A resident approached a co-resident, and performed an action that caused them to sustain injuries. A Personal Support Worker (PSW) who was present and the SOC both acknowledged that the co-resident was not protected from physical abuse.

Sources: Residents' clinical records, CI, and interview with the PSW and SOC.