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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 3, 4, 11, 12 PHB, 2012	2012_061129_0012	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

PHYLLIS HILTZ-BONTJE (129)

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 resident and a family member, registered staff, the Administrator, Director of Care and the Assistant Director of Care.

During the course of the inspection, the inspector(s) reviewed clinical record documents, home investigative notes as well as the homes policies and procedures in relation to Log #H-001925-12.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not protect resident #1 from abuse by anyone in relation to the following: [19(1)]
The licensee did not protect Resident # 1 from emotional abuse following a report of physical abuse made by the resident that involved a care provider when management staff allowed the care provider to continue to provide care to the resident for the remainder of the scheduled shift. It was confirmed that the resident was very frightened by this care provider following the alleged abuse, that the care provider continued to respond to the resident's care needs throughout the remainder of the shift and that the resident continues to experience fear that the care provider will come back into the room. The Administrator confirmed the incident of alleged abuse and that the care provider involved in this incident continued to respond to the resident for the five hours that remained in the care provider's scheduled shift.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that at a minimum the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports, in relation to the following: [20(2)(d)]
The Administrator confirmed that the homes policy [Prevention, Reporting and Elimination of Abuse and Neglect] identified as LTC1-05.01 and dated February 1, 2011 does not contained and explanation of the duty to make immediate reports to the Director under section 24 of the Act.
2. The licensee did not ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with, in respect to the following: [20(1)]
The Administrator confirmed that the homes policy [Prevention, Reporting and Elimination of Abuse and Neglect] identified as LTC1-05.01, dated February 1, 2011 directs that where and incident of suspected abuse involving an employee occurs, the employee shall immediately be placed on a leave of absence with pay from active duty pending further investigation was not complied with, when:
-The Administrator confirmed that the person in charge of the home did not immediately place a staff person on leave following a report by a resident that abuse had occurred.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Registered staff who had reasonable grounds to suspect that resident #1 had been abused by a care provider did not immediately report the suspicion and the information upon which it was based to the Director, in relation to the following: [24(1)2]
The Administrator confirmed that two registered staff who received a report from resident #1 alleging physical abuse by a care provider that caused the resident to experience pain, did not immediately initiate the online Mandatory Critical Incident form or use the after hours paging system to notify the Director that they suspected a resident had been abused by a staff member.
Registered staff confirmed both in documentation in the clinical record and in interviews notes conducted to investigate the allegations of abuse that they had a suspicion that abuse had occurred, that medication for pain was provided to the resident to manage pain following the alleged incident, that directions were provided at the time of the incident to document all activities with respect to this incident because there would be an abuse investigation conducted and that the police would be conducting a further investigation into the allegations.

Issued on this 11th day of October, 2012

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

Phyllis Hilts-Bontje

(Inspector signature on Licensee Report)