Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 18, 2013	2013_208141_0015	H-000317-13	Critical Incident System

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4, 6, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Supervisor of Care (SOC), Behaviour Support Ontario (BSO) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), and Pesonal Support Workers (PSW)

During the course of the inspection, the inspector(s) reviewed the residents records, home's investigation notes of incident, and the licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Resident #001 did not have the care provided as set out in the plan of care related to responsive behaviours.
The resident had a new strategy initiated in June, 2013 related to increased responsive behaviour. The resident's plan of care provided explanation and goal for the strategy.
On an identified date the documentation in the progress notes stated the strategy was not in place for a period of time and the resident exhibited the responsive behaviour. The charge nurse confirmed the strategy was not in place for the resident and assigned staff were not given the reason and expectations related to the strategy at the commencement of the shift. [s. 6. (7)]

2. The plan of care for resident #001 was not revised when the care set out in the plan had not been effective.
The resident's documentation did not include any incidents of identified responsive behaviour from November, 2012 to May, 2013. In May the resident had multiple incidents of responsive behaviours. The staff had a conference with the Psychogeriatric Resource Consultant (PRC) to identify strategies related to the resident's responsive behaviours in May, 2013 but the plan of care for the responsive behaviour that was not revised until June, 2013 after the resident had an another incident of responsive behaviour. [s. 6. (10) (c)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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:

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 license did not protect residents from abuse by an identified resident. Resident #001 had a history of responsive behaviours.
A) In May, 2013 the resident was observed to be exhibiting the responsive behaviour toward resident #002. The incident was not documented in resident #002 records. The registered staff who documented the incident did not include if a head to toe assessment had been completed for resident #002, or that the supervisor, physician or family were notified. The registered staff stated they had not completed an assessment or notified anyone of the incident. The DOC confirmed she was not aware of the incident until investigation of another incident occurring in June, 2013.
B) Resident #001 documented records indicated the resident had multiple incidents of responsive behaviour toward staff and residents in May 2013.
C) In May, 2013 the PRC completed a conference with the home area staff to discuss resident #001 responsive behaviours. The PRC made specific recommendations. No actions on the recommendations were initiated until after further responsive behaviours were observed by resident #001 in June, 2013. The resident plan of care for the responsive behaviour was not revised until June, 2013. The DOC confirmed the recommendations had not been acted on or the plan of care revised.
D)In June, 2013 the resident was observed to exhibit responsive behaviour toward resident #002. Post incident a staff member identified possible injury and reported this to the registered staff. There was no documentation by the registered staff who had first knowledge of the incident and possible injury that a head to toe assessment was completed or the physician was notified. The registered staff stated they had not completed an assessment or notified the physician. [s. 19. (1)]

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. Resident #001 did not have referral to a specialized resource integrated into their plan of care.
A) The resident was assessed by the Psychogeriatric Resource Consultant (PRC) through a conference with the staff in November, 2012, due to identified multiple responsive behaviours . A recommendation for referral to a specialized resource was identified. Staff confirmed that a referral had not been completed at that time to the specialized resource.
B) The home completed a conference with the PRC in May, 2013 due to increased responsive behaviours by the resident. Recommendations included referral to multiple specialized resources. During the inspection period staff confirmed referrals were in process but not yet completed. [s. 53. (2)]

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 there are protocols for referral of residents to specialized resources where required, to be implemented voluntarily.

WN #4: 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:

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).

Findings/Faits saillants :

1. The licensee did not ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with for resident #002. The homes policy and procedure "Prevention, Reporting and Elimination of Abuse/Neglect" (LTC 01-05.01) stated the definition of sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident/client.
The procedure stated when Abuse is suspected an employee who is advised of or who has first knowledge of abuse or suspected abuse shall immediately inform their supervisor, or if not available, the registered nurse (RN) in-charge. The supervisor or RN will immediately ensure the well being of the resident/client and render first aid or call an ambulance as appropriate; the Administrator and Director of Care will be immediately notified of any allegation/incident of abuse/neglect; the abused resident/client will be assessed by the Director of Care/designate or the In-Charge Nurse. If the abuse person is a resident, the person who completes the assessment will coordinate a medical examination of the resident by the first available attending physician; and the Administrator will provide notification of allegations of abuse to the Director, Long Term Care.
A) Resident #2 was observed in May, 2013 in their room with another resident exhibiting responsive behaviours. The male resident had a history of the responsive behaviour. The registered staff who had first knowledge of the incident did not immediately inform their supervisor or RN. The resident was not assessed or have a medical examination by a physician, and the Administrator, Director of Care or the Director of Long Term Care were not informed.
B) Resident #2 was observed in June, 2013 in a another resident's room with the other resident exhibiting responsive behaviour. The incident was observed and possible injury was reported. The registered staff who had first knowledge of the incident and possible injury did not complete an assessment of the resident, notify the the In-Charge nurse or the physician of the possible injury. The SOC confirmed that they were not informed of the possible injury and the physician had not been initially contacted.
The DOC confirmed that the procedure was not complied with for both incidents. [s. 20. (1)]

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Issued on this 19th day of June, 2013

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