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

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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
May 16, 2014	2014_215123_0003	H-000041-13,H-000128-13	Complaint

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, 22, 23, 24, 25, 28, 29, May 1 & 2, 2014.

Concurrent inspection #2014_215123_0004/H-000082-13

During the course of the inspection, the inspector(s) spoke with residents, the home's management team members including; the Director of Care, Supervisors of Care, the staff educator, and the Social Worker.

During the course of the inspection, the inspector(s) reviewed residents' records, reviewed the home's records, observed care rounds, inspected supplies and observed residents.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out, clear directions to staff and others who provide direct care to the resident.

The records of 37 identified residents were reviewed related to assessments for bed-mobility. Personal Support Worker (PSW) staff were interviewed and reported that the residents required the assistance of two staff members for bed-mobility. The PSWs also indicated that 37 plans of care should reflect that the residents required assistance of two or more persons to physically assist them to: Move to and from lying position; to turn side to side and to position their bodies while in bed.

35 of the 37 plans of care audited did not contain information specific to the residents requiring the assistance of two or more staff persons for bed-mobility. This information based on assessment of the residents was not included in the residents' plan of care.

The home failed to ensure that the written plan of care for each resident sets out, clear directions about bed-mobility, to staff and others who provide direct care to the residents. [s. 6. (1) (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 plan of care of all residents sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

There are 54 residents on each of the first and third floors of the home. The records of 23 identified residents of the first floor and 24 residents of the third floor were reviewed and the assessment documentation indicated that the residents required the assistance of two or more staff for bed-mobility including; movement to and from lying position, turning side to side and positioning of their bodies while in bed.

The home's night-shift staffing plan was reviewed and it included one Personal Support Worker (PSW) on each of the six home areas, one Registered Nurse (RN) on the first floor and one Registered Practical Nurse (RPN) on the third floor. The RN and the RPN each provide care for residents on three of the six home areas. The job routines of the registered staff on the night shift was reviewed and included sorting incontinence products for each of the three units for the day, evening and night shifts. The job routines for the PSW staff was reviewed and included cleaning wheelchairs.

Resident Assessment Instrument-Minimum Data Set (RAI-MDS) staff were

interviewed and confirmed that the assessment documentation was accurate. Front-line staff of the first and third floors were interviewed and reported that the majority of the residents required the assistance of two staff for bed-mobility and that they are assisted when providing care to these residents by the Personal Support Worker (PSW) from the adjacent home area or the registered staff if available.

The inspector was present in the home during the night shift of 01/05/2014 and observed that the staffing was provided as per the home's staffing plan. When the PSW staff from one home area of the first floor required assistance to provide care to a resident, they had to wait five to ten minutes for the staff from the adjacent home area to arrive. When the PSW left their home area to assist the staff with their request the home area was left without any staff present as the registered staff was on another attending to other duties. The inspector observed an identified resident wandering on the unattended unit which was not locked.
When the staff member went to the aid of the other staff member the unit was left unattended with one identified resident wandering the unit and one resident in the dining area.

Ten residents were observed on 01/05/2014 and five were not provided assistance with bed mobility as per their assessments. Five residents who required the assistance of two staff for bed mobility were provided assistance with bed mobility by one Personal Support Worker as observed by this inspector.

The home did not ensure that the staffing plan provided a staffing mix that was consistent with the resident's assessed needs. [s. 31. (3) (a)]

Issued on this 16th day of May, 2014

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