Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2021	2020_826606_0030	016537-20	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor 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

JANET GROUX (606)

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): December 3, 4, 7-10, 2020.

The following complaint intake was inspected:
Log #016537-20 regarding the Home's Falls Prevention and Management Program.

NOTE: A Non Compliance with O. Reg 79/10 section r. 107. (3) 4. issued from the Critical Inspection Inspection Report #2020_828606_0028 conducted concurrently will be issued in this inspection report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Supervisors of Care (SOC), the Falls Prevention and Management Program Lead, Behaviours Support of Ontario (BSO) Lead, Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), Physiotherapist (PT), Supervisor of Dietary Services (SDS), Dietary Aides, Cook, Substitute Decision Makers (SDM), and residents.

The inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plans of care, reviewed relevant home's investigation records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Pain
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches were considered in the revision of resident #001's care plan to manage their risk of falling.

Resident #001 sustained serious injuries after they fell several times during specified times during a shift.

Personal Support Worker (PSW) #108 and Registered Practical Nurse (RPN) #106 identified possible reasons why resident #001 was falling.

Resident #001’s care plan provided the staff various falls management strategies to manage the resident's risk of falling but did not include additional approaches to address the reason the resident was falling during the specified times.

Sources: progress notes, Initial Post Fall Assessments, care plan, and interviews with staff. [s. 6. (11) (b)]

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 if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Home’s Falls Prevention and Management Program was complied with for resident #001.

O. Reg. 79/10, s. 48. (1) requires a long-term care home to ensure a falls prevention and management program are developed and implemented to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the Home's "Falls Prevention and Management Program" policy.

Resident #001 had a history of falling prior to their admission and was considered at high risk for falls. On admission, the registered staff were required to complete an assessment to identify a resident's risk level for falling within 24 hours of their admission. Registered Nurse (RN) #107 and Supervisor of Care (SOC) #104 confirmed this.
This assessment was not completed for resident #001.

Sources: progress notes, Falls Prevention and Management Program" policy revised April 9, 2018, and staff interviews.

b) O. Reg. 79/10, s. 53. (1) requires a long term care home to ensure protocols for the referral of residents to specialized resources where required to meet the needs of residents with responsive behaviours are implemented.

Specifically, staff did not comply with the Home’s "Prevention and Management of Responsive Behaviour Program".

Resident #001 had a number of falls which resulted in serious injuries and caused a significant change in their condition.

During identified times, staff reported resident #001 exhibited a number of responsive behaviours. RPN #105, #106 and RN #107 acknowledged the resident's responsive behaviours and said they did not refer the resident to the Behavioural Support Nurse (BSO). The BSO Nurse said they did not receive a referral for resident #001's responsive behaviours.

Sources: progress notes, Home’s Policy "Prevention and Management of Responsive Behaviour Program” and staff interviews. [s. 8. (1) (a),s. 8. (1) (b)]

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 the Home's "Falls Prevention and Management Program", and "Prevention and Management of Responsive Behaviour Program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that fall prevention devices for resident #001 were readily available for them.

Resident #001 fell a number of times and it was identified the resident's falls prevention device/equipment were not in place at the time they fell. One of the resident's fall resulted in a serious injury.

Staff reported resident #001's falls prevention devices/equipments were not available. RN #107, RPN #105 acknowledged this.

Sources: progress notes, and interviews with staff. [s. 49. (3)]

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 equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure the Director was informed of resident #001's and #006's transfer to the hospital which resulted in a significant change in their health condition.

a) Review of the Long Term Care Homes Portal did not show evidence that the Home submitted a Critical Incident (CI) report for resident #001 and #006's falls on identified dates. The Director of Care (DOC) and the Supervisor of Care (SOC) #103 said the CIs were not submitted.

Sources: Long Term Care Homes Portal, CI report #M618-000016-20, and interviews with the DOC and SOC. [s. 107. (3) 4.]

Issued on this 21st day of January, 2021

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

Original report signed by the inspector.