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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Original Public Report

Report Issue Date: March 29, 2023	
Inspection Number: 2023-1613-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: The Regional Municipality of Peel	
Long Term Care Home and City: Malton Village Long Term Care Centre, Mississauga	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.03.31 15:43:13 -04'00'
Additional Inspector(s) Kehinde Sangill (741670)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 23- 24, 27- 28, March 1-3, and 6-7, 2023.

The following intake(s) were inspected:
Intake: #00003363 (CI#618-000006-22); #00018502 (CI#618-000003-23) related to care and services
Intake: #00015401 (CI#618-000034-22) was related to abuse
Intake: #00019641 (CI#618-000006-23) was related to multiple care areas
Intake: #00020568 (CI#618-000009-23) was related to falls.
Complaint Intake: #00020792 related to Care and Services.

The following intakes were completed in this inspection:
Intake: #00019489 (CI#618-000005-23) was related to Care and Services
Intake: #00015307 (CI#618-000033-22); #00017021 (CI#618-000038-22); #00018151 (CI#618-000001-23); #00020292-22 (CI#618-00007-23); were related to falls.

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

Resident Care and Support Services

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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)
O.Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to a non-residential area were kept locked with no access to residents.

Rationale and Summary
During the onsite inspection, the inspector observed a door leading to a non-residential area was left ajar by a piece of metal.

A staff acknowledged that they might have left the door opened, and that the door should be kept locked. The supervisor acknowledged that the expectation was that staff should be present while the door was opened and closed it once they were finished.

Sources: Observations; review of the home's "Door Security" policy, with revised date February 18, 2011; and staff interviews. [698]

Date Remedy Implemented: February 24, 2023.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care related to fall interventions was provided to a resident.

Rationale and Summary
A resident was at high risk for falls and required an intervention to help alert staff when they required attention.

During observation on a unit in the home, a resident was observed to need staff assistance. The inspector immediately called for help. A staff responded and assisted the resident. The fall intervention that was in place to assist the resident was not activated.

The staff told the inspector that it was their responsibility to prevent and respond to falls by ensuring that resident's needs were met. The supervisor acknowledged that the resident required the intervention to be functioning and alert staff as a part of the resident's fall interventions.

Sources: Observations; review of resident's clinical records; review of Falls policy with revised date November 21, 2018; and staff interviews. [698]

Date Remedy Implemented: February 24, 2023.

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that a policy directive that applied to the Long-Term Care Home (LTCH), the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

In accordance with the Directive, licensees were required to ensure that Alcohol Based Hand Rub (ABHR) products used were not expired as set out in the document, "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes".

Rationale and Summary
During onsite observation, three expired bottles of ABHR were observed at the screeners' station. On

the same day, another bottle of expired hand sanitizer was observed in the second-floor dining room.

On two separate dates, expired wall mounted hand sanitizers and bottles of free standing sanitizers were observed on a unit.

A staff verified that the bottles of hand sanitizers were expired, and they were responsible for ensuring expired products were not in circulation.

The expired products were removed.

Sources: Observations; Review of "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes" document revised November 6, 2020; staff interviews. [741670]

Date Remedy Implemented: March 6, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented.

Rationale and Summary
A resident who required assistance at least twice per day with a particular care, showed that the care was being documented as provided, once per day. Their plan of care indicated that the care should be provided twice a day. Between January 2022 to January 2023, the care was documented as being done once a day.

A PSW verified that the care was provided to residents twice a day and could only be documented in the system as once a day.

A coordinator noted that this routine care task was programmed in the system to be done once a day and as needed (PRN).

Several PSWs, indicated they were unaware that this particular care should be documented in the PRN section of system's task.

The Director of Care (DOC) acknowledged that this particular routine care task should have been programmed to twice a day in the system for accurate documentation.

Failure of staff to document the resident's care twice per day increased the risk of inadequate monitoring of the resident's health.

Sources: The resident's clinical record; interviews with the DOC and others. [741670]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that a verbal complaint made to the home concerning the care of a resident was investigated and a response including what was done to resolve the complaint provided within 10 business days.

Rationale and Summary
A verbal complaint was made to the home regarding a resident. The complaint was documented in the resident's progress note. A second complaint was made to the home in writing by the complainant, to follow up.

The home had a process in place for addressing verbal and written complaints including completing a complaint and recommendation form. No records were found in the complaint binder to indicate that the home followed up with the verbal complaint that was made by the complainant.

The DOC acknowledged that they were unaware of the verbal complaint and that the home's complaint process was not followed.

Failure to initiate the home's complaint process in a timely manner led to a delay in identifying and responding to concerns related to resident's care.

Sources: The home's complaint binder, Home's Policy on Reporting and Managing Complaints and Recommendations (LTC1-05.05, revised April 15, 2019); interview with the DOC and other staff. [741670]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, related to their care.

Rationale and Summary
A resident's electronic record directed PSWs to offer the resident a specified intervention after each meal as per the specialist's recommendations.

A PSW did not offer the intervention to the resident after a particular meal.

The PSW verified that they did not offer the resident the intervention as they were unaware of the specialist's recommendation.

The resident depended on staff for care. There was a risk to the resident health when staff did not follow the specialist recommendation.

Sources: Resident's clinical records; interviews with the PSW and other staff. [741670]

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC) Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the IPAC lead carried out their responsibility related to routine practices and additional precautions.

The IPAC lead failed to ensure that additional precautions were followed in accordance with the IPAC Standards. Specifically, the IPAC lead did not ensure the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal as is required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary

A Registered Practical Nurse (RPN) was observed entering the room of a residents on droplet and contact precaution wearing a mask and face covering. The signage on the door indicated that mask, face covering, gloves and long-sleeved gown was required.

A Personal Support Worker (PSW) was observed wearing a gown, gloves, face shield and N95 mask in the hallway while carrying soiled laundry in a COVID-19 outbreak unit. On the same day, a second PSW was observed in the hallway unit wearing N95 mask and holding the face shield in their hand.

The first PSW acknowledged they were not wearing the required PPE; and he second PSW acknowledged they should remove PPE in the room where care was provided and perform hand hygiene (HH) before walking down the hallway on a unit that was in COVID 19 outbreak.

The IPAC lead acknowledged that full PPE was required when providing care for the roommate of a resident on isolation and contact precaution and that staff should discard used PPE once they exited the room where it was used.

Failure of staff to adhere with PPE requirements may compromise the long-term care home's IPAC efforts.

Sources: Observations; review of IPAC Standards; interviews with IPAC Lead and other staff. [741670]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary
A medication cart was observed unlocked and unattended, and accessible with residents' medications.

The DOC acknowledged that medication carts should be locked when left unattended.

The home's Medication policy indicated that registered staff should never leave unlocked medication cart unattended.
Failure of staff to lock the medication cart when unattended placed residents at risk of ingesting

medications that were not prescribed for them.

Sources: Observation of unlocked medication cart; interview with the RPN and Director of Care (DOC). [741670]