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: September 18, 2024

Inspection Number: 2024-1613-0003

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Malton Village Long Term Care Centre, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6-9, 12-16, 19 and 20, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00115414/ CI #M618-000026-24, #00115439/ CI #M618-000025-24, #00117802/ CI #M618-000035-24 were related to fall of resident.
- Intake: #00116588/ CI #M618-000029-24, #00119512 / CI #M618-000040-24, #00123743/ CI #M618-000047-24 were related to resident-to-resident abuse.

- Intake: #00118897/ CI #M618-000036-24 was related to resident-to-resident physical altercation.
- Intake: #00118984/ CI #M618-000038-24 was related to neglect of resident.
- Intake: #00121670/ CI #M618-000042-24 was related to related to staff-to-resident abuse resulting in resident injury.

- Intake: #00122529/ CI #M618-000044-24 was related to attempted suicide by resident.

The following complaint intake was inspected:

- Intake: #00116001 was a complaint related to neglect, improper/ incompetent care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The home has failed to ensure that they provided a safe and secure environment for

a resident.

Rationale and Summary

A resident was sent to hospital following a suicide attempt. Registered Nurse (RN) stated that the resident had a tendency to collect a large number of items in their room and had several hazardous items in their room at the time of the incident. It is unknown how the resident obtained these items.

During an observation of resident's room several hazardous items were noted in their room.

According to the resident's care plan, staff were required to conduct environmental checks and remove any items that could be used to facilitate a suicide attempt. The home's Suicide Risk Assessment and Prevention Policy listed cords, linens, medications, plastic bags, sharp objects, toxic substances, and safety devices as potential hazards and directed staff removing items that could be used to facilitate a suicide attempt.

Supervisor of Care (SOC) confirmed that staff completed environmental scan every shift and should have removed hazardous items from the resident's room. SOC also acknowledged that the home failed to ensure a safe and secure environment for the resident.

The home failed to provide a safe and secure environment for the resident by not removing potential hazardous items.

Sources: Observations in the resident room, review of Critical Incident (CI) report, resident's clinical records, interviews with registered staff and SOC.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

The licensee has failed to ensure that the staff involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with each other.

Rationale and Summary
A resident was assessed by RN to use a device as a personal assistance service device (PASD) at the time of admission. The device was included as part of the resident's care plan as a falls prevention measure. Physician assessed the resident's device as a restraint in the Restraint Consent Form and documented in the progress notes.

During an observation, Personal Support Worker (PSW), identified the device as a PASD. Physiotherapist (PT) and Supervisor of Care (SOC) were not aware of the physician's assessment of the device to be a restraint. They acknowledged the resident's device was identified as a PASD in their plan of care but were being used as a restraint to restrict the resident's movements. Registered Practical Nurse (RPN), PT and SOC were not aware Physician had assessed the device as a restraint. SOC confirmed when the PASD was changed to a restraint by the physician, the plan of

care was not updated.

Failure to ensure that staff members collaborated for consistent assessment of resident's usage of the device as a restraint placed the resident's wellbeing and safety at risk.

Sources: Observation, review of PASD consent form, Restraint consent form, progress notes, and care plan, interviews with PSW, RPN, RN, PT, SOCs.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure to check resident for safety as specified in the plan.

Rationale and Summary:
A resident was sent to hospital following a suicide attempt.

The resident's care plan specified that staff were required to check on the resident at specific intervals for safety and document these checks. Observations conducted twice on an identified date revealed that no staff had performed the required safety checks during those periods.

PSW mentioned that they did observe the resident when passing by in the hallway

but could not specify the times of these checks. The PSW also acknowledged that failing to complete the safety checks increased the risk of a suicide attempt by the resident.

SOC confirmed that staff were expected to perform safety checks as outlined in the care plan.

Failure to carry out the safety checks as per the care plan compromised resident's safety.

Sources: Observations, review of resident's clinical records, interviews with PSW and SOC.

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect resident #004 from physical abuse by resident #005.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident”.

Rationale and Summary
A Critical Incident System (CIS) was reported to the Director, related to an incident of

resident-to-resident physical abuse.

Resident #005 was observed by PSW pulling resident #004 out of a room, and began hitting them. This led to resident #004 falling on the floor causing injuries. A pain assessment was performed, indicating a certain level of pain for resident #004.

PSW acknowledged that the incident was witnessed by them. SOC acknowledged that resident #005 physically abused resident #004 causing injury and pain.

The home's failure to protect resident #004 from being abused by resident #005 resulted in an injury to resident #004.

Sources: Review of CI report, residents' clinical records, interviews with PSW, and SOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's altered skin conditions were reassessed weekly by registered nursing staff.

Rationale and Summary

A resident's body part was found with altered skin conditions. The resident had initial skin and wound assessment completed by the registered staff, however there was no weekly skin and wound assessment completed for the identified week of that month.

The home's policy titled "Skin and Wound Care Program" indicated for a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, they must be assessed at least weekly.

RN and SOC, both stated that resident's skin alterations should have been assessed weekly using the skin and wound assessment and the weekly assessment was not completed for the identified week of that month.

There was increased risk of inadequate skin monitoring and treatment when weekly skin assessments were not completed.

Sources: Review of Long -term Care Home's (LTCH) Skin and Wound Care Program, resident's clinical records, interviews with RN and SOC.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

4. Protocols for the referral of residents to specialized resources where required.

The licensee failed to ensure that the protocol for referral of residents to specialized resources was complied with to meet the needs of the residents with responsive behaviours.

In accordance with Ontario Regulations (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that there were protocols for referral of residents to specialized resources where required to meet the needs of residents with responsive behaviours. and must be complied with.

Specifically, home did not comply with the policy, "Prevention and Management of Responsive Behaviors Program", which directed the registered staff referring residents to Behaviour Support Ontario (BSO) when they exhibited new responsive behaviours.

Rationale and Summary
i) The home submitted a Critical Incident (CI) report following an incident where resident #007 prevented resident #006 from leaving a resident home area by shaking their mobility aid and yelling at them, which caused emotional distress to resident #006.

Following the incident, resident #007 was assessed to be at a certain level of risk for violence. During interview, RN confirmed that since resident #007 had exhibited new responsive behaviors, there were no prior interventions in place to manage the behaviours. The staff acknowledged that a BSO referral should have been submitted to assess resident #007 but was not.

SOC confirmed that the BSO referral was not completed and stated that the

registered staff should have referred resident #007 to the BSO nurse to address the exhibited behaviors.

Failure to refer the resident to a specialized resource when necessary posed a risk of missing an opportunity to manage the resident's responsive behaviors effectively.

Sources: Review of CI report, resident's clinical records, LTCH's Prevention and Management of Responsive Behaviors Program, interview with registered staff and SOC.

Rationale and Summary
ii) A CIS was submitted to the Director related to alleged abuse of a resident. Record review of a resident's progress notes indicated that the resident had sustained skin impairments, during care.

PSW and RPN confirmed that the resident had shown ongoing responsive behaviours on various occasions during one of their shifts. SOC confirmed that the staff in the home were expected to initiate a referral to BSO when the resident had new onset of responsive behaviours. SOC acknowledged that the home had failed to refer the resident to a BSO for further assessment and management of resident's responsive behaviors.

Failure to refer the resident to a specialized resource, when necessary, posed a risk of missing an opportunity to manage the resident's responsive behaviors effectively.

Sources: Review of CI report, LTCH's policy "Prevention and Management of Responsive Behaviour Program", resident's clinical records, interview with PSW RN, RPN and SOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to ensure that for a resident who had responsive behaviours, their behavioural triggers were identified.

Rationale and Summary
A resident exhibited responsive behaviours of verbal and physical aggression towards residents and staff.

At the time of the inspection, resident's written plan of care had identified several triggers for their responsive behaviours.

During interviews with Activation Therapist (AT), RPNs, PSWs, RN, and SOC. all had stated that the resident had several additional triggers. However, these additional triggers for the resident's verbal and physical aggression were not included in the resident's plan of care, leaving a gap in managing and responding to their responsive behaviors.

Failure to include all identified triggers in the resident's plan of care may have impaired the staff ability to deescalate behaviours and prevent further incidents.

Sources: Resident's clinical records, interviews with AT, RPNs, PSWs, RN, and SOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible

The licensee has failed to ensure that for a resident, strategies were developed and implemented to respond to their responsive behaviours.

Rationale and Summary
A CIS report was submitted to the Director. The CIS report indicated a resident had sustained skin impairments during the provision of care.

The home's policy on "Prevention and Management of Responsive Behaviour Program" directed staff to initiate a care plan which includes identifying the type of responsive behavior and behavior triggers, developing, and implementing strategies to prevent, minimize or manage the responsive behavior in collaboration with the interdisciplinary team.

Resident's progress notes revealed that the resident had exhibited responsive behaviours, on a number of occasions for a period of approximately five years. However, strategies were not developed to manage the responsive behaviour of resistiveness prior to an incident on an identified month of this year, that caused an

injury to the resident.

PSW acknowledged that the resident exhibited the identified responsive behaviours almost daily when staff provided care to them. RPN acknowledged that strategies should have been identified in the resident's care plan to manage responsive behaviours. SOC acknowledged that the resident had exhibited the identified responsive behaviour as documented in the progress notes on multiple occasions with no interventions addressing those behaviours until the incident that caused an injury to the resident.

Failing to develop and implement strategies for the resident's responsive behaviours resulted in staff being unaware of strategies that could prevent the behaviours and potential injuries.

Sources: Review of CI report, LTCH's "Prevention and Management of Responsive Behaviour Program" policy, resident's clinical records, interview with PSW, RN, RPN and SOC.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents

The licensee has failed to ensure that interventions were implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary
Resident's progress notes for a certain period of time indicated that the resident exhibited numerous verbal and physical responsive behaviours towards co-residents and staff.

(i) Resident's care plan instructions stated they were on certain type of intervention on every shift. On an identified date, resident #005 was observed by PSW pulling resident #004 out of room and began hitting and punching them. This led to resident #004 falling on the floor causing injuries. At the time of the incident, resident #005 did not have the specified intervention in place.

PSW acknowledged that the incident was witnessed by them where resident #005 physically hit and kicked resident #004 and they did not have the specified intervention at the time of the incident. SOC acknowledged that resident #005's care plan instructions were not implemented.

(ii) A resident's plan of care instructed staff to monitor the resident closely and separate them from others if the resident was in close contact with others. The care plan also indicated to ensure distance is maintained between resident #005 and residents #004, #010, #011, #012 and 013.

During an observation completed on an identified date, resident #005 was seen sitting in the dining room at the same table along with residents #011 and #012. PSW acknowledged that resident #005 was sitting with residents #011 and #012,

however no attempts were made to separate resident #005 from the other residents and distance was not maintained between residents as per resident #005's care plan instructions.

SOC acknowledged that the care plan instructions were not implemented to maintain distance between residents and resident #005 was not separated when noted sitting with residents #011 and #012.

(iii) Resident #005's care plan instructions stated they were on certain type of intervention on every shift.

AT acknowledged seeing resident #005 standing near resident #004 on an identified date, and the specific type of intervention was not implemented with resident #005. RN confirmed that the specific intervention was not implemented for the resident on that date. SOC acknowledged that the care plan instructions were not implemented.

iv) Resident #005's plan of care instructed staff to provide a certain type of intervention and separate them from others if the resident was in close contact with others. On an identified date, resident #004 was sitting in a home area with a PSW when resident #005 walked behind and grabbed the back of the clothing protector that resident #004 had on. RPN reported that at the time of the incident, there was no staff member present to provide the specified intervention as required by the care plan instructions.

SOC acknowledged care plan instructions were not followed.

(v) Resident #005's plan of care instructed staff to provide a certain type of intervention and separate them from others if the resident was in close contact with

others. The care plan also indicated to ensure distance was maintained between the resident #005 and residents #004, #010, #011, #012 and 013. On an identified date, it was documented by RPN that both residents #004 and #005 were seen sitting in a home area, and resident #005 initiated physical contact with resident #004 causing an alteration to their skin. No attempts were made to separate residents before and after the incident.

RPN acknowledged both residents were together in the home area before and after the incident. SOC acknowledged that the home should have utilized interventions as indicated in resident #005's care plan to manage their responsive behaviours, but these interventions were not implemented by staff.

Failure to implement interventions for resident #005 from their responsive behavioural plan of care have caused injury to resident #004 and put other residents at risk of harm.

Sources: Observations, review of CI report, residents' clinical records, interviews with PSWs, RN, RPNs, AT and SOC.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the

Excellent Care for All Act, 2010,

The licensee has failed to ensure that the responses to written complaints included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:
The home received a complaint from a substitute decision maker for a resident and, another complaint came in from a substitute decision maker for another resident concerning the care and services provided to the residents.

A review of the licensee's response emails to these complaints revealed that neither response included the Ministry's toll-free phone number and its hours of service or contact details for the patient ombudsman.

SOC confirmed that the responses to both the substitute decision makers lacked the Ministry's toll-free phone number and its hours of service and patient ombudsman contact information.

Failure to provide Ministry's toll-free telephone number for making complaints about home and contact information for the patient ombudsman did not place the residents at risk.

Sources: Review of CI report, LTCH's response letters sent to the complainants, and interview with the SOC.

WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 118 (e)
Policy to minimize restraining of residents, etc.
s. 118. Every licensee of a long-term care home shall ensure that the home's written policy under section 33 of the Act deals with,
(e) how consent to the use of physical devices as set out in section 35 of the Act and the use of PASDs as set out in section 36 of the Act is to be obtained and documented;

The licensee has failed to comply with the home's policies, developed for how consent for the use of a restraint was to be obtained and documented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the home's minimizing restraint use policy related to documenting consent was complied with.

Specifically, staff did not comply with the home's policy "Minimizing restraint use and the use of Personal Assistance Services Devices (PASD) Program", that directed staff to obtain documented consent from a resident's substitute decision-maker (SDM) for the use of a device as restraints.

Rationale and Summary
On an identified date, Physician assessed a resident use of a device as a restraint in the Restraint Consent Form. They documented in the progress notes that restraints were discussed with the resident's substitute decision-maker (SDM). The resident's SDM had signed a consent form for use of the device as a PASD a few days before the Physician assessment.

The home's policy, "Minimizing restraint use and the use of Personal Assistance Services Devices (PASD) Program" states that every use of a physical device to restraint a resident must have documented consent. RN, SOC #116 and SOC #117 confirmed that when the device was changed from a PASD to restraint, a new consent form was required to be signed by the resident's SDM, but it was not completed.

Failure to ensure consent was obtained from resident's SDM when purpose of the device changed from a PASD to a restraint posed risks to resident's safety and well-being.

Sources: Restraint consent form, LTCH's "Minimizing restraint use and the use of Personal Assistance Services Devices (PASD) Program" policy, progress notes; interviews with RN, SOCs.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee ensured that medications for a resident were stored in an area that was secured and locked.

Rationale and Summary

The home submitted a CI report after a resident was hospitalized following a suicide attempt.

During an observation in a resident's room, a bottle of hazardous solution was left on the nightstand and prescription topical cream was found in the drawer of the shared washroom.

SOC confirmed that these medications should have been stored in a secure, locked area, not within the resident's room.

Failure to properly secure resident's medications posed a risk to resident if the medications were consumed without supervision.

Sources: Observations, review of CI report, interview with SOC.