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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2016	2016_556168_0031	034601-16	Resident Quality Inspection

Licensee/Titulaire de permis

PARKVIEW HEALTH CARE PARTNERSHIP (THE)
284 SUNSET DRIVE OAKVILLE ON L6L 3M4

Long-Term Care Home/Foyer de soins de longue durée

PARKVIEW NURSING CENTRE
545 KING STREET WEST HAMILTON ON L8P 1C1

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

LISA VINK (168), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 16, 19, 20 and 21, 2016.

The following concurrent inspections were conducted with this RQI.
Complaints inspections:
Log number 014700-16, IL-44591-HA - related to duty to protect, continence care and bowel management, plan of care and housekeeping.
Log number 011826-16, IL-44329-HA - related to residents` bill of rights, laundry service, prevention of abuse and neglect and availability of supplies.

Critical Incident:
Log number 031469-16, 2700-000008-15 - related to reporting certain matters to the Director and transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, (DOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, Occupational Therapist (OT), maintenance staff, families and residents.

During the course of this inspection, the inspectors: observed the provision of care and services, toured the home, reviewed relevant records including but not limited to: meeting minutes, policies and procedures and clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **4 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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given the opportunity to participate fully in the development and implementation of the resident`s plan of care.

According to the clinical record in 2016, resident #018, was identified to experience shortness of breath and low oxygen saturation ranging from 73-83 percent with oxygen applied, during the night. On two separate occasions the resident requested to go to the hospital; however, was informed that their physician would visit later that day and would assess the resident at that time. Later that morning the physician assessed the resident who agreed to transport them to hospital as this was the request of the resident, who was now agitated and competent to make the decision. The resident was transferred and admitted to the hospital following the physician`s visit.

According to the clinical record, on an identified date in 2016, at 1030 hours, resident #018 called the nurse and reported they were short of breath and requested to go to the hospital. The resident's oxygen saturation was 74 percent with oxygen applied. The RN was notified of the request and rechecked the resident's oxygen saturation which was recorded at 84 percent with oxygen applied. The resident was not sent to the hospital as requested. The following day at 0906 hours, the resident's oxygen saturation was 63 percent with oxygen applied, at which time they were transferred and admitted to the hospital.

The home did not give the resident the opportunity to participate fully in the development and implementation of their plan of care for the examples identified above, which was confirmed by the DOC, following a review of the clinical record. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. Resident #001's clinical record identified that they had a physician's order for a monthly intervention. The electronic Treatment Administration Record (eTAR) identified that the intervention was scheduled to occur on December 12, 2016. The eTAR was not signed on December 12, 2016, to indicate that the interventions was completed, nor was there documentation in the progress notes to indicate the intervention had occurred. Interview with RN #102 on December 19, 2016, who worked on the shift the December

12, 2016, verified that the intervention was not completed as specified in the resident's plan. (Inspector 506)

B. Resident #020 previously had an order for oxygen (O2) therapy. The physician's order for O2 was discontinued in early 2015, and an assessment completed by ProResp in the summer 2015, identified that the resident did not qualify for home oxygen. The resident was observed on December 16, 2016, to be using O2, via nasal prongs in their room. Interview with RPN #104, verified that the resident currently used O2 therapy. A review of the current physician's orders did not include an order for the use of O2, as confirmed with the RPN. Interview with the DOC identified that when the therapy was discontinued the O2 concentrator remained in the resident's room and for that reason they continued the use of the O2. The DOC obtained an order, from the physician, for the therapy to resume on December 21, 2016.
Care was not provided as per the plan of care when the resident continued to receive O2 therapy after the physician`s order in early 2015 until December 20, 2016. (Inspector 168)

C. Resident #014 had an order in place for the use of continuous O2 and required the assistance of staff to receive the therapy. On an identified date in 2015, the resident did not have their oxygen applied for greater than one hour according to investigative notes provided by the home. The resident had a diagnosis which supported the use of the therapy and staff confirmed the resident used their O2 continuously. PSW #109 and #112 confirmed that they did not follow the resident's plan of care when they failed to apply the O2 on the identified date as required. [s. 6. (7)]

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was kept clean.

On December 16, 2016, a tour of the home was completed. During this tour, balls of paper towel were placed on the floors, behind the doors, of three identified rooms. The paper towels were still present on the floors, in two of the three rooms, on December 19, 2016, and in one of the three rooms on December 21, 2016, as observed by the Inspector. Interview with housekeeping staff #114 verified the expectation that all resident rooms, including the floors, be cleaned seven days a week, which was outlined in the Environmental Services policy and procedure manual related to Housekeeping - Section 3.0.
The floors of the home were not consistently kept clean as evidenced by debris remaining on the floors as observed by the inspector. [s. 15. (2) (a)]

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 home is kept clean, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #014 was transferred using safe transferring and positioning techniques.

A review of the home's investigation notes, identified that on a specific date in 2015, at approximately 1330 hours, resident #014 had been placed in a mechanical lift to transfer them into bed when it was noted that the mattress was not inflated. PSW #113 and #112 did not transfer the resident to bed, but rather, proceeded to leave them in the lift, above the bed and exited the room to tend to other residents. The resident was left unattended in the room, in the lift, in a raised position. Interview with PSW #112 confirmed PSW #113 informed the resident's primary PSW #109 that the resident was left suspended; however, PSW #109 on December 20, 2016, identified they were unaware that PSW #113 reported a concern regarding the resident or the mattress and thought the staff put the resident to bed. PSW #109 confirmed that they did not complete a final round at 1400 hours on the resident as required in their job routine. The resident was found around 1500 hours by the evening staff.
Interviews conducted with the DOC and PSWs involved in the incident confirmed that safe transferring and positioning techniques were not used on the identified date. [s. 36.]

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 residents are transferred using safe transferring and positioning techniques, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included, body mass index and height upon admission and annually thereafter.

During a review of clinical records it was identified that a number of residents did not have heights recorded on a yearly basis.
The "Weights and Vitals Summary" report was reviewed and identified that seven of ten residents on two separate floors did not have heights documented annually. Interview with the DOC confirmed the expectation that heights be completed annually on all residents. Interview with RN #104 confirmed that these seven residents did not have their annual heights taken.
The home did not ensure that all residents had their heights completed and documented annually in their clinical records. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration programs includes, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

Issued on this 23rd day of December, 2016

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

Original report signed by the inspector.