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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2020	2020_745690_0005	016165-19	Critical Incident System

Licensee/Titulaire de permis

The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner
201-80 Speers Road OAKVILLE ON L6K 2E6

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 18-20, 2020.

The following intake was completed in this Critical Incident inspection:
-One log, which was a Critical Incident that the home submitted to the Director related to a fall that resulted in an injury and a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector reviewed internal investigation notes, relevant resident health care records, licensee policies, procedures and programs and observed the provisions of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

Ontario

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. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident (CI) report was submitted to the Director, related to a resident that had fallen and sustained an injury that resulted in a significant change in the resident’s health status. The CI report indicated that resident #001 had fallen while performing an identified Activity of Daily Living (ADL) and sustained an identified injury.

A review of resident #001’s electronic care plan, that was in place at the time of the inspection, identified that the resident required an identified level of assistance to perform ADLs. The care plan included interventions for three of the ADLs that had conflicting information on what level of assistance the resident required for each of the three ADLs.

In separate interviews with Personal Support Worker (PSW) #101 and, PSW #106, they indicated that resident #001 required a specified level of assistance to perform ADLs and that they would check the care plan to find out what care and assistance a resident required.

In separate interviews with Registered Practical Nurse (RPN) #102, RPN #107, and Registered Nurse (RN) #103, they all indicated that staff would check the resident’s care plan to find information on what care and assistance a resident required. RPN #102, RPN #107, and RN #103 viewed resident #001’s electronic care plan with the Inspector and they identified that the care plan did not provide clear direction on what level of assistance the resident required to perform the identified ADLs, and that it should have.

In an interview with the Director of Care (DOC), they indicated that the care plan for resident #001 did not provide clear direction to staff related to the three identified ADLs and that it should have. [s. 6. (1) (c)]

Issued on this 25th day of February, 2020

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

Original report signed by the inspector.