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
Oct 26, 2021	2021_877632_0020	005318-21, 009518-21, 009585-21, 012012-21, 013211-21	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

YULIYA FEDOTOVA (632), CAROLIN THOMAS (705120)

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): October 8, 11-14, 18-19, 2021.

The following Critical Incident System (CIS) inspection was completed:
log #005318-21, 009518-21, 009585-21, 013211-21 - related to falls prevention;
log #012012-21 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC)/Infection Prevention and Control (IPAC) Lead, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Occupational Therapist (OT), and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors toured the home and completed the IPAC checklist inspection, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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).

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 a written plan of care for resident set out clear directions to staff and others who provided direct care to the resident.

A resident's written plan of care indicated to provide an identified assistance to the resident during identified activity.

Documentation Survey Report for an identified period in October 2021, indicated that a specified assistance to the resident was provided identified number of times.

PSWs' #116 and #118 indicated that currently, the resident required the specified assistance with identified activity.

The PT confirmed specified status of the resident related to identified activities.

The resident was at risk of falls as a result the directions related to the specified assistance with identified activity in their written plan of care were not clear.

Sources: resident's written plan of care; Documentation Survey Report; interviews with PSW #116, PSW #118 and the PT. [s. 6. (1) (c)]

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.

On identified dates in October 2021, a resident was observed in an identified location with no specified falls prevention measure in place.

The resident's care plan indicated that the specified fall prevention measure was to be in place.

An RPN identified that the specified fall prevention measure was needed, while the resident was in the identified location.

The resident was at risk of injury in the event of a fall in the identified location, when the specified fall prevention measure was not in place.

Sources: resident's written plan of care; observations; interview with RPN #110. [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 and ensuring that a written plan of care for resident that sets out clear directions to staff and others who provide direct care to the resident and 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the IPAC program.

On an identified date in October 2021, inspector observed a room with no contact precaution signage posted on the bed room door.

A resident's care plan had a focus on specified health status.

Minimum Data Set (MDS) confirmed the resident's specified health status.

The IPAC policy required residents, who had specified health status, to be placed on precautions.

An RN confirmed that there was no precautions signage posted on the bed room door of the room.

The ADOC confirmed that all residents with specified health status should have Personal Protective Equipment (PPE) available and signage posted on the residents' bedroom doors.

There was a risk of spreading the infection without the precaution signage in place.

Sources: resident's care plan, MDS, the IPAC policy; observations; interviews with RN #120 and the ADOC. [s. 229. (4)]

Issued on this 27th day of October, 2021

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

Original report signed by the inspector.