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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
May 15, 2015	2015_334565_0009	T-1722-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE MENNONITE HOME ASSOCIATION OF YORK COUNTY
123 Weldon Road Stouffville ON L4A 0G8

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

PARKVIEW HOME LONG-TERM CARE
123 Weldon Road Stouffville ON L4A 0G8

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

MATTHEW CHIU (565), BARBARA PARISOTTO (558), MONICA NOURI (193)

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): May 4, 5, 6, 7, 8, 11, 12, 13, 2015.

The following critical incident intakes were inspected concurrently with this Resident Quality Inspection: T-233-14 and T-2015-15.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining observation, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), director of program services, physiotherapist, director of nutritional services (DNS), dietary aides (DA), psycho-geriatric nurse consultant (PGNC), registered staff, personal support workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

9 WN(s)
2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

A. Record review indicated resident #21 was independent with activities of daily living (ADL), had mild cognitive impairment and exhibited identified inappropriate behaviours towards specific residents.
1. Record review indicated resident #23 was cognitively impaired. On a specified date, resident #21 exhibited inappropriate responsive behaviours toward resident #23. A staff member observed the incident, intervened and separated the residents. Resident #23 did not demonstrate any distress after the incident. Interviews with the PSW and DOC confirmed the above mentioned incident took place and resident #23 was unable to give consent.
2. Record review indicated resident #24 was cognitively impaired. On two identified dates, resident #21 was observed by visitors in the home and direct care staff exhibiting inappropriate responsive behaviours toward resident #24 in an identified home area. Interview with direct care staff and registered staff confirmed the incident took place and resident #24 was unable to give consent. Resident #24 did not demonstrate any distress after the incident.
3. Record review indicated resident #25 was cognitively impaired. On an identified date, resident #21 was observed by a PSW exhibiting inappropriate responsive behaviours toward resident #25. When the PSW entered the area and called his/her name he/she stopped and left the area denying his/her actions.
Interview with direct care staff and registered staff confirmed the incident took place and resident #25 was unable to give consent. Resident #25 did not demonstrate any distress after the incident.

B. Record review indicated resident #22 and #26 were cognitively impaired. On an identified date, resident #22 exhibited identified responsive behaviours and pushed resident #26 onto the floor in the hallway. Resident #26 sustained a minor injury to an identified area.
Interview with the ADOC and a registered staff confirmed the incident took place. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report immediately the suspicion of abuse of the resident by anyone and the information upon which it was based to the Director.

Record review and DOC interview confirmed the following three incidents of suspected sexual abuse were not reported to the Director:
- on an identified date, resident #21 was observed by a PSW abusing a co-resident.
- on two identified dates, resident #21 was observed by visitors in the home and direct care staff abusing another co-resident.

Record review and DOC interview confirmed the following three critical incidents of suspected abuse were not reported to the Director immediately:
- two identified critical incidents in early 2014, were reported three and four days after the incidents respectively.
- one identified critical incident in early 2015, was reported two days after the incident. [s. 24. (1)]

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 anyone who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #1's plan of care sets out clear directions to staff and others who provide direct care to the resident in relation to the toileting schedule.

Review of resident #1's care plan and kardex, available to the direct care staff, indicated to toilet the resident according to the toileting routine. There was no explanation what this routine implied.
Interview with the identified PSW on day shift revealed the resident is toileted one time per shift, before breakfast.
The home's Continence management policy # RC-11-05 approved on October, 2013, and reviewed annually, indicates the registered staff shall initiate a care plan based on the resident's continence assessment that would include interventions with clear instructions to guide the provision of care (e.g. the times the resident is to be toileted).
The identified staff member indicated the expectation for toileting when a resident is on a toileting schedule is to be completed in the morning, after meals and at night before going to bed. He/She confirmed the resident's plan of care does not give clear directions

to staff on the toileting schedule. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident in relation to monitoring whereabouts.

Review of the resident #21's plan of care for an identified period in 2014 and 2015 indicated for staff to monitor his/her whereabouts in relation with his/her identified inappropriate behaviour towards residents with opposite sex. There is no indication of frequency of monitoring.
Interview with direct care staff and registered staff and DOC confirmed the frequency of monitoring the resident's whereabouts was not clearly indicated in his plan of care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Interview with resident #2 revealed he/she receives oral care once a day in the evening and no oral care in the morning.
Record review of resident #2's plan of care indicated staff should assist the resident in cleaning his/her mouth using oral swab or tooth brush in the morning and evening.
Interview with a PSW confirmed he/she was not aware of resident #2's plan of care indicating the resident should receive staff assistance for oral care in the morning. [s. 6. (8)]

4. The licensee has failed to ensure that when the resident is being reassessed, the plan of care is being revised because the care set out in the plan has not been effective and different approaches have been considered in the revision of the plan of care.

Progress notes review identified resident #21 exhibited identified inappropriate responsive behaviours on numerous occasions in mid 2014.
Review of the resident's plan of care for the identified period in 2014, and interview with an identified registered staff confirmed the resident's plan of care did not identify the consideration of different approaches in the revision of the plan of care. [s. 6. (11) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures.

Interview with resident #2 revealed he/she requires staff assistance to clean his/her mouth and dentures, and he/she receives oral care once a day in the evening and no oral care in the morning.
Record review of resident #2's plan of care indicated staff should assist the resident in cleaning his/her mouth using oral swab or tooth brush in the morning and evening.
Interview with a PSW confirmed he/she did not provide oral care to the resident in the morning. [s. 34. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #1 and #4 who are incontinent received an assessment that includes identification of causal factors and potential to restore function with specific interventions.

Record review and interview with the identified staff member confirmed that the home uses Resident profile assessment and 3 day continence diary (on admission and when there are changes in resident's condition), and Minimum Data Set assessments (quarterly). These assessments instruments do not include the identification of causal factors and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
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; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

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

An identified critical incident report identified alleged resident to resident abuse between resident #22 and resident #26. Record review and staff interviews revealed resident #22 had a history of identified responsive behaviours. Staff described an identified behavioural trigger for resident #22 over resident #26. On the identified date, resident #22 pushed resident #26 who landed on the floor. Following the incident, residents were separated. Resident #26 was found with no injuries and resident #22 was administered a medication for the identified responsive behaviour.
Staff interviews confirmed no interventions were developed or implemented to minimize the risk of re-occurrence of potentially harmful interactions between resident #22 and #26 after this incident.
One week later, another identified critical incident report identified another alleged resident to resident abuse between resident #22 and resident #26 when resident #22 pushed resident #26 again. Resident #26 sustained a minor injury. [s. 55. (a)]

WN #7: 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 has failed to ensure that there is a weight monitoring system to measure and record each resident's height annually.

a. A record review revealed resident #7's height was taken on admission on an identified date in 2009.
b. A record review revealed resident #5's height was taken on admission on an identified date in 2013.
c. A record review revealed resident #1's height was taken on admission on an identified date in 2012.
An interview with the DOC confirmed the above mentioned residents' heights had not been taken annually thereafter since admission. [s. 68. (2) (e) (ii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

Record review and interview with the identified staff member confirmed that 17.4% of the staff who provide direct care to residents did not receive training related to continence and bowel management in 2014 as required. [s. 221. (1) 3.]

WN #9: 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. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that all pets visiting as part of a pet visitation program have up-to-date immunizations.

Review of the home's Visiting pets registration record and interview with the Programs manager indicated that 10 dogs and one cat visiting as part of a pet visitation program did not have up-to-date immunizations. [s. 229. (12)]

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Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.