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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_370649_0019	024714-17	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

JULIEANN HING (649), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 1, 2, 3, 6, and 7, 2017.

During the course of the inspection, the inspector(s) spoke with the administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Regisitered Dietitian (RD), Resource Nurse, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Makers (SDMs), and residents.

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

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_168202_0011	565
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2016_168202_0011	649

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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home’s quarterly medication incident reports for the last quarter indicated there were two incident reports involving residents #006 and #007.

Resident #006 had been administered a topical medication for a longer period of time than it had been prescribed. An identified topical medication was supposed to have been removed on an identified time and date, and was found on the resident the following morning, when the new medication was scheduled to be applied. Resident #007 had not received his/her medication on an identified date and at a scheduled time even though it was signed on the electronic medication administration record (eMAR) as given, the medication strip pack was found in the resident’s medication bin on the medication cart the following day.

Interview with Registered Practical Nurse (RPN) #100 who discovered that the topical medication had not been removed from resident #006 on an identified evening shift at an identified time and who also discovered resident #007’s medication was not given to the resident on an identified date at a scheduled time confirmed that he/she had not notified the residents' attending physician and the medical director of the medication incidents.

Interview with the Assistant Director of Care (ADOC) revealed that the attending physician and the medical director should have been informed of the medication incidents involving residents #006 and #007 at the time they had occurred. [s. 135. (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 o ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, 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 has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Resident #001 triggered from stage one of the Resident Quality Inspection (RQI) for accommodation services of housekeeping related to unclean ambulation equipment.

On November 1, 2017, at an identified time resident #001's chair for which he/she was sitting in was observed to be soiled on both sides of the chair. Another observation on November 3, 2017, at an identified time revealed resident #001's chair was dirty with food stains on the left and right sides of the chair. On November 6, 2017, at an identified time resident #001's chair was observed by the inspector to have stains on the right handle and both sides of the chair of what appeared to be dried foods and beverages.

A review of the home's policy titled PSW Routine - Nights (2200 - 0600), policy #RC-03-30-05, approved date of April 2014, and reviewed date on April 2017, directed the cleaning of wheelchair, geri-chair and walker cleaning on Rouge Valley Terrace unit every Wednesday.

Interview with Personal Support Worker (PSW) #105 on an identified date and time revealed that all nursing staff are responsible to ensure the resident's chair is clean and the night staff are assigned to clean the chair while the resident is in bed. The PSW confirmed there were food marks on the right arm rest and food or drink stains on the sides of resident #001's chair. The PSW cleaned the resident chair when he/she took the resident to the washroom.

Interview with RPN #106 on an identified date and time revealed that before the resident is transferred into the chair the PSW staff should look at the chair and wipe it down if dirty. The RPN told the inspector that the seat cover on the chair needs to be washed and confirmed there were splashes of foods or drinks on the chair which should be sprayed down and cleaned as some of the spots do not look new.

Interview with the ADOC revealed that the actual cleaning of the chair is assigned to the night PSW but all staff are responsible. The ADOC stated that spills and debris should be cleaned at the time they occur or as soon as they are observed and during the weekly scheduled cleaning the chair should be thoroughly cleaned to remove debris. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Resident #004 triggered from stage one of the RQI related to altered skin integrity.

According to the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment on an identified date, indicated the resident has two areas of altered skin integrity. A review of the resident's plan of care on an identified date, indicated the resident is at high risk of altered skin integrity related to immobility, poor nutritional intake and weight loss.

A review of the initial skin assessment completed on an identified date indicated resident #004 has altered skin integrity on an identified body area.

A review of the home's policy titled Skin and Wound Care program, policy #RC-13-45, approved on September 2017, directed the Dietitian to reassess resident with new or worsening pressure ulcers and reassess when the ulcers have healed.

Interview with RPN #100 revealed that he/she can communicate with the Registered Dietitian (RD) about the altered skin integrity but must complete the dietary referral in point click care (PCC). The RPN confirmed the referral to the RD was not completed.

Interview with ADOC confirmed that no referral had been sent to the RD on paper or documented in PCC when resident #004 was identified with altered skin integrity on an identified body area.

Interview with the RD #101 revealed that he/she had not received a referral for resident #004 and had not assessed the resident when he/she developed the altered skin integrity on an identified body area when it was first identified. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #004 triggered from stage one of the RQI related to altered skin integrity.

According to the most recent RAI-MDS assessment indicated the resident has altered skin integrity. A review of the resident's most current plan of care indicated the resident is at high risk for skin breakdown related to immobility, poor nutritional intake and weight loss.

A review of the initial skin assessment completed in PCC indicated resident #004 was identified with altered skin integrity on an identified body area.

A review of 004's clinical record and staff interview indicated that weekly skin and wound assessment are documented under the assessment tab in PCC and in the progress notes. A review of the skin and wound assessments and progress notes indicated no weekly skin assessments were completed on identified dates, after resident #004 was identified with altered skin integrity on an identified body area.

A review of the home's policy titled Skin and Wound Care program, policy #RC-13-45, approved date of September 2017, directed the registered staff to reassess wound

weekly and document assessment in point click care (PCC).

Interview with RPN #100 revealed that no weekly skin assessments had been completed for resident #004 for the altered skin integrity on identified dates.

Interview with ADOC revealed there should have been weekly skin assessments completed and documented on identified dates for resident #004 by a registered staff for the altered skin integrity to an identified body area. [s. 50. (2) (b) (iv)]

Issued on this 5th day of December, 2017

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

Original report signed by the inspector.