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 prévue 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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 24, 2019 | 2019_685648_0001 | 006396-17, 011187-17, 021831-17, 025828-17, 000229-18, 003362-18, 019750-18, 020658-18, 020902-18, 025916-18, 029246-18 | Critical Incident System |

### 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

JOVAIRIA AWAN (648)

## 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): March 18, 20, 25, 26, 27, 28, 29, 2019, and, April 01, 02, 03, 04, 05, 08, 09, 10, 2019.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Resource Nurse (RRN), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Assistant Director of Care (ADOC), Director of Care (DOC), and the homes Administrator.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**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)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,**
**(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and**
**(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection.

A review of a critical incident system report submitted to the MOHLTC on an identified date, identified resident #003 sustained an injury on an identified date and was subsequently transferred to hospital the same day following assessment by nursing staff which identified an injury.

Prior to the hospitalization, resident #003's was identified to be independent in ambulation requiring supervision with no use of mobility aides. Review of resident #003's written plan of care prior to the hospitalization on the identified date of the CIS, identified resident required supervision to extensive assistance for activities of daily living (ADL), and transfer assistance with no identified use of transfer equipment.

Resident #003 was discharged and returned from hospital at a later date, with an identified diagnosis and injury. Following a physiotherapy assessment post

hospitalization it was determined that the resident was unable to ambulate independently and required the use of a mobility aide for long distance transfers, required extensive to total assistance for ADL's and was to be assisted by staff for all transfers. A health status change note documented on the day of return from hospital, identified the resident with a Significant Change in Status related to their change in transfer and assistance level for activities of daily living.

The home reported the critical incident on an identified date four business days following the CI incident, to the MOHLTC as noted in the CIS report, and confirmed by the DOC.

The licensee failed to ensure where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection. [s. 107. (3.1)]

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**Issued on this 24th day of April, 2019**

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

**Original report signed by the inspector.**