Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 4, 2019	2019_626501_0019	030041-18, 000484-19, 013184-19	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

SUSAN SEMEREDY (501), ASAL FOULADGAR (751)

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): August 20, 21, 22, 23, and 26, 2019.

During this inspection the following critical incident system (CIS) reports were inspected:

Log #000484-19 related to the prevention of abuse
Log #013184-19 related to falls prevention
Log #030041-18 related to medication

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), an agency supervisor, agency PSW, and residents.

During the course of inspection, the inspector(s) conducted observations of personal care, staff and resident interactions and the provision of care, and reviewed health records, home’s investigation records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 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	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. (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 :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a critical incident system (CIS) report to the Ministry of Long-Term Care (MLTC) related to resident #002 reporting to Assistant Director of Care (ADOC) #103 that a staff member treated them in an identified manner.

An interview with ADOC #105 indicated resident #002 first came to them complaining about an area of their body and then indicated a staff member treated them in an identified manner. The ADOC further indicated they listened to a voicemail left by RPN #106 indicating resident #002's substitute decision-maker (SDM) had a concern. The ADOC contacted the SDM who indicated resident #002 stated a staff member transferred them on their own, without using an assistive device, which caused them to have pain. The ADOC stated the physician examined resident #002 and found no evidence of altered skin integrity. An x-ray was ordered which came back negative.

An interview with DOC #100 indicated the home investigated the above incident and found that personal support worker (PSW) #105 had worked on the above-mentioned date. PSW #105 had been assigned to resident #002 and matched the description of the staff member resident #002 stated transferred them without an assistive device.

Review of resident #002's plan of care indicated the resident used an identified assistive device with extensive assistive from two staff for transfers.

An interview with PSW #104 indicated resident #002 has always needed an identified assistive device due to an identified physical condition. The PSW stated they were aware resident #002 had been transferred without an assistive device by a staff member without assistance. The PSW indicated that at the time that this incident occurred, plans of care were accessible to all staff in binders at the nursing station.

An interview with PSW #105 acknowledged they transferred resident #002 without using an assistive device or having assistance from another staff member. The PSW stated they did not have access to the home's Kardexes or plans of care.

An interview with DOC #100 indicated that PSW #105 was aware of how to access the home's plans of care. The DOC confirmed PSW #105 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
[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 to ensure that 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

The MLTC received a critical incident system (CIS) report indicating resident #001 did not receive their scheduled medications. The resident had returned from the hospital on an identified date and was transferred back to the hospital a few days later due to an unstable condition.

The inspector reviewed resident #001’s order summary report upon the resident’s return to the home. This report indicated an identified oral medication was to be held and an identified injectable medication was to be renewed.

A review of progress notes indicated resident #001 was readmitted to the home on an identified date and hour. A note a day later indicated renewed medications including the identified injectable medication, were not given to resident #001 on the evening of the resident’s readmission to the home as they were not delivered by pharmacy.

A review of resident #001’s physicians’ orders two days after the resident’s readmission, indicated an identified oral medication was to be restarted. A review of the home’s investigation notes indicated RPN #108 did not administer the identified oral medication on an identified date and hour as it was not delivered to the home until a few hours later.

An interview with RPN #108, confirmed that on the above-mentioned identified date, they did not administer the identified oral medication. RPN #108 further indicated they did not inform the physician or the charge nurse for further direction.

Further progress notes a few days after readmission indicated resident #001 was exhibiting a change in their condition. The resident was transferred to the hospital as ordered by the on-call physician and a further note indicated the resident had been admitted with an identified diagnosis.

An interview with DOC #100 indicated that resident #001 did not receive the above-mentioned medications because the pharmacy did not deliver them in a timely manner.

The home failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.
[s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.