Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Feb 13, 2020	2020_715672_0001	023360-19	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

JENNIFER BATTEN (672)

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): January 30 and 31, 2020

The following intakes were inspected during this Critical Incident System inspection:

One intake related to a Critical Incident Report regarding a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the President of the home, the Director of Care (DOC), Associate Director of Care (ADOC), Administrative Assistant (AA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI-MDS Coordinator, Resource Nurse, family members, residents and visitors to the home.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed employee training records, schedules and the following policies: Falls Prevention Program and Head Injury Routine.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 49 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Inspector #672 reviewed an internal policy related to head injury routine, which directed how, when and for how long the resident was to be assessed by a member of the registered nursing staff.

Review of the Head Injury Routine monitoring form indicated the instructions for completing the head injury routine assessments were as indicated in the internal policy.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #001. The CIR indicated the fall resulted in an identified injury.

While reviewing resident #001’s health care record and documentation related to the fall, Inspector #672 observed resident #001 was placed on head injury routine (HIR). Inspector #672 reviewed the HIR documentation and noted the assessments and documentation had not been completed according to the internal policy.

Inspector #672 then reviewed the head injury routine assessments completed for resident #001 during a specified period of time, and noted the resident had received HIR assessment on a number of other occasions. Upon review, Inspector #672 noted the assessments and documentation had not been completed according to the internal policy, as entries were missing or documented that assessments were not done because resident #001 was sleeping or attending another activity.

Inspector #672 then expanded the scope of the inspection to include two more residents who had recently received head injury routine assessment within the home, to determine if staff had assessed the resident and documented the head injury routine assessments as required within the internal head injury routine policy. Inspector #672 was provided with the name of resident #004 from RPN #104 and the name of resident #005 from RPN #106, who indicated both residents had received head injury routine assessments within the home in the previous 180 days.

Related to resident #004:

Resident #004 was assessed to be at a high risk for falls, and required head injury routine assessments after an identified number of previous falls sustained.

During review of resident #004’s progress notes and head injury routine assessments completed during a specified period of time, Inspector #672 noted that resident #004 had received head injury routine assessment on an identified number of occasions. Upon review, Inspector #672 noted the resident had not been assessed according to the internal head injury routine policy.

The record review of the HIR assessments indicated that there were multiple occasions when the resident was not assessed according to the policy because the resident was allegedly sleeping.

Related to resident #005:

Resident #005 was assessed to be at a high risk for falls, and required head injury routine assessments after an identified number of previous falls sustained.

During review of resident #005’s progress notes and head injury routine assessments completed during a specified period of time, Inspector #672 noted that resident #005 had received head injury routine assessment on an identified number of occasions. Upon

review, Inspector #672 noted the resident had not been assessed according to the internal head injury routine policy.

According to the HIR document, there were several times during the assessment period that the assessments were not completed. According to the documentation, the resident was sleeping or was at another activity.

During separate interviews, RN #105 and RPNs #107 and #108 indicated the expectation throughout the home was for the head injury routine assessments to be completed and documented in full as directed on the head injury routine assessment form.

During separate interviews, RPNs #104 and #106 indicated it was a routine practice in the home for head injury routine assessments to not be completed according to the instructions listed on the assessment forms in certain situations, such as if a resident were at an activity, eating or sleeping. RPN #104 further indicated if a resident's assessment was due around a meal time, the nurse should complete the assessment either prior to or following the meal but should not miss completing the assessment altogether.

During separate interviews, the DOC and ADOC indicated the expectation throughout the home was for the registered staff to complete the head injury routine assessments according to the directions listed within the internal policy and the head injury routine assessment forms. The DOC and ADOC further indicated it was not acceptable to not complete a resident assessment due to the resident being at a meal, attending an activity or sleeping. The DOC and ADOC indicated if the resident refused the assessment for any reasons, the expectation would be for the nurse to document the resident had refused in the progress notes and on the head injury routine assessment form. The DOC reviewed resident #001, #004 and #005's head injury routine assessment forms with Inspector #672 and indicated the resident had not been assessed and the documents had not been completed in full, according to the internal head injury routine policy.

The licensee failed to ensure the internal policy related to head injury routines was complied with when the head injury routine assessments were not completed in full following falls sustained by residents #001, #004 and #005. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.