Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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
Oct 19, 2021	2021_882760_0037	003024-21, 007463-21, 008309-21, 008483-21, 010412-21, 010414-21, 014515-21	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

JACK SHI (760), FRANK GONG (694426)

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): October 12, 13, 14, 15, 2021.

The following intakes were completed in this critical incident inspection:

Four logs were related to a fall;
A log was related to an allegation of improper care;
A follow up log to Compliance Order (CO) #001, LTCHA s. 19 (1), related to prevention of abuse and neglect, issued under inspection #2021_875501_0012, on June 29, 2021, with a compliance date of August 31, 2021, was inspected;
A follow up log to Compliance Order (CO) #002, O. Reg 79/10 s. 24 (2), related to falls prevention, issued under inspection #2021_875501_0012, on June 29, 2021, with a compliance date of August 31, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with a Resident Care Assistant (RCA), the Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 WN(s)**
- **2 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	2021_875501_0012	760
O.Reg 79/10 s. 24. (2)	CO #002	2021_875501_0012	760

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 :

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

A resident was noted to be at risk for fall injuries and an intervention was implemented based on their care needs and noted in their plan of care.

An observation of the resident noted that this intervention was not in place. An RPN verified that this intervention was implemented in the resident's plan of care but was not in place. ADOC acknowledged that the intervention should have been in place.

Failure to ensure that the care set out in the plan of care was provided to the resident as specified in the plan may result in further falls and injuries to the resident.

Sources: A Critical Incident Systems report, observations, the resident's plan of care and progress notes, interview with an RPN and ADOC. [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 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A dietary aide was observed wearing face mask beneath their nose; they acknowledged that they were aware of IPAC requirements and the face mask should have covered their nose.

An observation demonstrated that a resident on precautions did not have face shields readily available. An RPN verified that face shields were not available in the Personal Protective Equipment (PPE) caddy and should have been restocked.

Failure to ensure that staff participated in the implementation of the infection prevention and control program may increase the risk and transmission of infectious disease.

Sources: Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition from Public Health Ontario 2012, observations, and interview with a dietary aide, an RPN and other staff. [s. 229. (4)]

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 ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used a safe positioning device for a resident.

According to the report and the home's investigation, the resident sustained an injury after being transferred by a PSW on a wheelchair. The resident's medical chart indicated they had risk factors that predisposed them to an injury. The PT stated that due to these risk factors, interventions should have been implemented and considered to reduce the resident's risk for injury when they were using a wheelchair. Failure to ensure the resident had interventions in place to safely use their wheelchair resulted in an injury.

Sources: The home's investigation and critical incident report; a resident's medical chart; Interviews with the PT and other staff. [s. 36.]

Issued on this 19th day of October, 2021

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

Original report signed by the inspector.