Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
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Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1451_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Mennonite Home Association of York County

Long-Term Care Home and City
Parkview Home Long-Term Care, Stouffville

Lead Inspector
Asal Fouladgar (751)

Additional Inspector(s)
Lucia Kwok (752) was present during the inspection.

Inspector Digital Signature
Digitally signed by Asal Fouladgar
Date: 2022.09.15 07:48:50 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15, 16, 18, 2022

The following intake(s) were inspected:

- An intake related to fall prevention and management
- An intake related to infection control and prevention

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

The Infection Prevention and Control (IPAC) standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 9.1, stated that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. In addition, under section 9 (f), the licensee shall ensure additional Personal Protective Equipment (PPE) requirements included the appropriate selection, application, removal and disposal.

During the inspection, Inspector #751 observed signages of Contact/Droplet precautions on two resident rooms' doors. The inspector also noted additional signages on each door indicating COVID-19 Droplet/Contact Precautions.

The Assistant Director of Care (ADOC) stated that the residents in those rooms were under contact precautions only and the additional signages related to COVID-19 were not supposed to be there, and they were just there to guide the staff for donning and doffing PPE.

The ADOC confirmed that the additional COVID-19 signages were misleading information and immediately removed both signages from the doors.

Sources: Observation, Interview with ADOC

Date Remedy Implemented: August 15, 2022 [751]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer necessary.

Rationale and Summary

A Critical incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), related to a resident's injury after an incident. The resident's current written plan of care indicated they were to use a special medical equipment and that they required a specific mobility device.

During the course of inspection, inspector #751 observed that the resident was using a different type of mobility device which was not identified in their care plan.

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Personal Support Worker (PSW) #100 and Registered Practical Nurse (RPN) #101 confirmed that the resident no longer required to use the specific mobility device and medical equipment. Restorative staff #103 and the Physiotherapist stated the same and noted that the resident required to use them for a specific period after their injury, however they no longer needed to use them.

RPN #101 stated that the resident's current plan of care did not reflect their current condition and it had to be revised when their care needs changed.

Failure to revise the resident's plan of care when required, would pose potential risk of harm to the resident.

Sources: Observations, Interviews with PSW #100, RPN #101, restorative staff #103, and Physiotherapist; The resident's clinic records.

[751]