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

Central East District
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Original Public Report

Report Issue Date: June 30, 2023	
Inspection Number: 2023-1451-0004	
Inspection Type: Critical Incident System	
Licensee: The Mennonite Home Association of York County	
Long Term Care Home and City: Parkview Home Long-Term Care, Stouffville	
Lead Inspector Miko Hawken (724)	**Inspector Digital Signature**
Additional Inspector(s) Lucia Kwok (752) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 8, 9, 12, 13, 2023

The following intake(s) were inspected:

- An intake related to staff to resident improper care resulting in injury.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A Critical Incident Report (CIR) was submitted related to improper care of resident resulting in an injury.

Resident progress notes indicated they had an injury and the physician ordered a diagnostic intervention for diagnosis that was delayed.

Assistant Directors of Care (ADOCs) and the Director of Care (DOC) acknowledged that there was a delay in the diagnosis and treatment of resident.

The failure of the long term care home (LTCH) staff to follow-up on the ordered intervention delayed the diagnosis and treatment of resident's injury.

Sources: CIR, resident's clinical health records, interviews with ADOCs and the DOC. [724]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, upon their return from hospital.

Rationale and Summary

A CIR was submitted related to improper care of resident resulting in an injury.

The resident's clinical health records showed that a registered staff member did not complete a skin assessment for a resident on their readmission to the LTCH from hospital.

The ADOC stated that the home's process was for registered staff to use the head to toe assessment in

Point Click Care (PCC) to assess impaired skin areas.

Failure to complete the skin assessment upon a residents return from hospital, might have impacted staff from monitoring and managing the resident's skin impairments.

Sources: CIR, resident's clinical health records, interview with assistant ADOC. [724]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A CIR was submitted regarding an incident that injured a resident.

Resident's clinical health records indicated there was an injury. However, registered staff failed to complete a skin and wound assessment for this injury.

Staff and the ADOC confirmed that the injury was considered altered skin integrity and a skin and wound assessment was not completed for resident's injury.

Failure to complete a skin and wound care assessment for the resident, might have impacted staff from monitoring and managing the resident’s skin condition.

Sources: CIR, resident clinical health records, interviews with staff and ADOC. [724]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

A CIR was submitted regarding an incident, that injured a resident.

The resident's clinical health records, indicated there was an injury.

The resident's clinical health records revealed that weekly skin assessments were not completed for the injury identified.

ADOC confirmed that resident's weekly skin assessments were not completed for the specified time periods.

Failure to complete a weekly skin assessment might have prevented the staff from monitoring the injury, posing a risk for further altered skin integrity and circulation at the site of the injury.

Sources: CIR, resident's clinical health records, interview with ADOC. [724]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)

The licensee failed to ensure that a resident that was exhibiting a skin condition that was likely to respond to nutritional interventions was assessed by a Registered Dietitian (RD).

Rationale and Summary

A CIR was submitted regarding an incident that injured a resident.

A review of resident's skin assessments indicated that there were multiple skin assessments completed for resident related to skin impairments.

The resident's clinical records indicated that no referrals made by registered staff to the RD for these skin impairments and no RD assessments were completed related to the skin impairments.

The ADOC verified that a referral to the RD was to be completed with any impairment to the skin and confirmed referrals were not completed by registered staff for any of the skin impairments.

Failure to have a RD assessment completed may have increased the risk of slow wound healing to resident's skin impairments, related to unidentified nutritional deficiencies and the lack of nutritional interventions.

Source: CIR, resident's clinical health records, interview with ADOC. [724]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that a resident's pain which was not relieved by initial interventions, was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A CIR was submitted to the Director regarding an incident that injured a resident.

The resident's clinical records indicated that a staff member informed a registered staff member that a resident was still having significant pain to their injury site after a dose of as needed (PRN) pain medication was not effective. The medication administration record (MAR) had only PRN pain medication ordered for the resident's pain management.

In another incident, the resident's clinical records indicated the staff member spoke to a registered staff member to inform them that resident was again having significant pain. No pain medication was administered or any other pain modalities were documented in the resident's clinical records.

Clinical records indicated that there were no pain assessments for the resident and that the resident had uncontrolled pain from the injury.

The ADOC and DOC acknowledged that the resident's pain was not relieved by the initial intervention of PRN pain medication and was not assessed using a clinically appropriate assessment instrument for pain.

Failure to complete pain assessments for the resident did not ensure their pain was managed and monitored appropriately and thus increasing pain and suffering.

Sources: CIR, resident's electronic health records, interviews with ADOC and the DOC. [724]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 64

The licensee failed to ensure that when transferring and positioning of a resident, staff used devices and techniques that maintained or improved, residents weight bearing capability, endurance, and range of motion.

Rationale and Summary

A CIR was submitted to the Director regarding an incident with the use of a device, that injured a resident. The type of device was not indicated in the CIR.

The LTCH investigation notes did not indicate what type of device was used in the incident.

Observations conducted by Inspector #724 found that there was only one type of device available for use on resident's home unit.

The resident plan of care stated that another device was to be used.

The LTCH staff described the devices had specific uses and physical indications to use on residents and that the home did not have a process or assessment for the devices use.

Staff who were present during the incident stated they used another device for the resident as they had specific needs for care.

ADOC's and the DOC stated they were not aware of the differences in the devices and there was no process or assessment used to choose a device for residents.

Failure to ensure that staff used the appropriate device increased the risk to resident, to deconditioning and maintaining their physical function.

Sources: CIR, LTCH's investigation notes, resident's clinical health records, observations, interviews with staff, ADOCs and the DOC. [724]