Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 24, 2023	
Inspection Number: 2023-1451-0006	
Inspection Type: Critical Incident	
Licensee: The Mennonite Home Association of York County	
Long Term Care Home and City: Parkview Home Long-Term Care, Stouffville	
Lead Inspector Marian Keith (741757)	**Inspector Digital Signature** Marian P Keith Digitally signed by Marian P Keith Date: 2023.10.31 13:39:55 -04'00'
Additional Inspector(s) Tiffany Forde (741746) Lucia Kwok (752) was present.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16 -19, 2023

The following intake(s) were inspected:

- Two intakes related to staff to resident abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Designated lead

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 70

The licensee has failed to ensure there was a designated lead for the home's Restorative Care (RC) program.

Rationale and Summary:
The Director received a Critical Incident Report (CIR) regarding an injury to a resident which required transfer to an outside facility.

The Administrator acknowledged the home has had staffing concerns and has not been able to replace the lead for the home's RC program. Upon review of the Long-Term Care Home (LTCH)'s directory, it was noted in the key personnel contact sheet, no lead was listed for the RC program.

As a result of the home not having a RC program lead, there was potential risk of the lack of delivery of RC approaches.

Sources: CIR, LTCH's Directory list, interviews with Staff and Administrator.

[741746]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with.

Rationale and Summary:

In accordance with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, effective August 30, 2022, section 1.1 states the licensee was required to ensure that Infection Prevention and Control (IPAC) self-assessment audits at least quarterly, in alignment with the requirement under the IPAC standard. When a home is in COVID-19 outbreak, IPAC self-assessment

audits must be completed weekly.

The home was declared in outbreak by Public Health (PH) on August 29, 2023, and the outbreak was declared closed by PH on September 22, 2023. In review of the home's COVID-19 self-assessment audits, there was no audit conducted during a week while the home was still in outbreak.

The IPAC Lead confirmed that all of the COVID-19 self-assessment audits were contained in the outbreak binder.

Failure to conduct the COVID-19 self-assessment audit on a weekly basis during an outbreak may put the residents at risk by not identifying potential IPAC risks while the outbreak is in progress, and therefore delaying any response by the home to IPAC concerns captured by the audit.

Sources: Interview with IPAC Lead, Review of IPAC documents

[741757]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that routine practices using personal protective equipment (PPE) are being followed in the IPAC program.

Rationale and Summary:

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard), section 9.1 (d) directs the licensee to ensure that routine practices and additional precautions are followed in the IPAC program, including the proper use of PPE, appropriate selection, application, removal, and disposal.

During the tour of the home, staff #111 was observed wearing a single glove on their right hand when cleaning a resident's room, which included tasks in the resident's bathroom. The home had implemented a Universal Mask mandate for staff and visitors. Staff #112 was observed wearing their medical mask below their nose while in close proximity (less than six feet) to another staff member.

Staff #109 and the IPAC Lead confirmed the expectation of staff are to wear two gloves as per Routine

Practices, and the proper wearing of masks was confirmed by the IPAC Lead where staff are required to wear the mask above the nose and pinch the mask over the bridge.

Failure to ensure Routine Practices with proper use of PPE are being followed increases the risk of transmission of infectious agents throughout the home.

Sources: Observations, Interviews with Staff #109 and IPAC Lead

[741757]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure symptoms indicating the presence of infection in a resident are monitored and recorded in the progress notes each shift.

Rationale and Summary:

A resident exhibited symptoms of infection on a specific date and was discharged from isolation on another specific date. In review of progress notes and vital sign records, assessments were not documented on all shifts and daily vital signs were not completed for the duration of infection symptoms.

A Registered Practical Nurse (RPN) confirmed the expectation of registered staff was to monitor and assess each resident with symptoms of infection each shift and document in their progress notes and perform daily vital sign screening.

The failure to monitor residents with symptoms of infection on each shift put residents at risk by not determining changes to residents' condition and any subsequent intervention required to support the residents' health and well-being.

Sources: Resident’s clinical records, Interviews with RPN and IPAC Lead

[741757]