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
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Original Public Report

Report Issue Date: January 17, 2024	
Inspection Number: 2023-1451-0007	
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 Maria Paola Pistritto (741736)	**Inspector Digital Signature** Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2024.01.18 14:18:46 -05'00'
Additional Inspector(s) Reethamol Sebastian (741747)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4-5, 8, 2024

The following intake(s) were inspected:

- One intake related to improper care of resident.
- Five intakes related to a fall with injury

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: TRANSFERING AND POSITIONING TECHNIQUE

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used a safe transferring device when assisting the resident.

Rationale and Summary

A Critical Incident Report (CIR) related to improper care for the resident was submitted to the Director. The CIR indicated that the resident had a fall while transferring.

Assistant Director of Care (ADOC) #113 and Registered Practice Nurse (RPN) #106 indicated that the staff did not use the appropriate assistive device to transfer the resident.

The physiotherapist (PT) recommended that the resident be on specific restrictions. The resident's care plan indicated the use of a specific assistive device for transfers. The Director of Care (DOC) confirmed the expectation was to use a specific transfer device for the resident.

The home's policy titled "Falls Prevention Program", directs staff to assist residents with safe transferring and ambulating techniques as per the care plan.

Failure to transfer the resident without their specific assistive device caused them to fall.

Sources: CIR #2968-000009-23, resident's clinical records, the home's policy titled "Falls Prevention Program" last revised March 2023, and interviews with staff. [741747]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2). The licensee has failed to choose the appropriate solution to clean shared assistive devices from isolation rooms.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, last revised September 2023, section 9.1 (e) (i) states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program including use of environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

Rationale and Summary

Inspector #741736 observed PSW #103 providing care to a resident on additional precautions. After the care, they proceeded to remove Personal Protective

Equipment (PPE) and clean the shared assistive devices. Inspector #741736 observed PSW #103 put hand sanitizer on rolled paper towels and attempt to clean the assistive device.

PSW #103 acknowledged they used the hand sanitizer and rolled paper towels to clean the assistive device, stating there was no cleaning supplies available. However, on observation, the PPE caddy outside of the room contained supplies of sanitizing wipes.

Failure to use the appropriate cleaning supplies to clean shared devices puts residents at risk for infection.

Sources: observation and interview with staff. [741736]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.

Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who were involved in the incident.

Rationale and Summary

A CIR related to improper/incompetent care of a resident was submitted to the Director. The CIR did not include the names of the staff members who were involved in the incident.

The resident's progress notes documented they were injured while PSW #105 was transferring the resident. In another incident, the fall assessment indicated the resident had a fall during a transfer. The DOC confirmed that all staff names were not included for both incidents in the CIR.

Failure to include the names of staff members who were present at or discovered the incident puts residents at risk of harm if those involved were not identified and interviewed.

Sources: CIR #2968-000009-23, resident's clinical record, and interview with the DOC. [741747]