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

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Original Public Report

Report Issue Date: February 23, 2024

Inspection Number: 2024-1451-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: The Mennonite Home Association of York County

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

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Siu F Tang — Digitally signed by Siu F Tang Date: 2024.02.27 07:26:09 -05'00'

Additional Inspector(s)
Asal Fouladgar (751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-9, 12-14, 2024.

The following intake(s) were inspected:

- An intake related to a Proactive Compliance Inspection.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Quality Improvement

Reporting and Complaints
Resident Care and Support Services
Residents' and Family Councils
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

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

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that all staff received retraining on the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports.

Rationale and Summary

With reference to FLTCA 2021, s. 82 (1) and s. 82 (2) 3 all staff are required to receive training on the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports.

Review of the home's training record indicated that only 88.5 percent (%) of the staff completed the required training for the year 2023. The home's training and orientation program Lead confirmed the same.

There was risk that all staff may not be familiar with the home's abuse policy as well as their duty under section 28 of the FLTCA 2021, to make mandatory reports, when they did not receive this required annual training.

Sources: The home's mandatory training records for year 2023, Interview with the home's lead for Training and Orientation Program.
[751]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(f) clearly indicates when activated where the signal is coming from; and

The licensee has failed to ensure that a call bell in a resident's room was activated and clearly indicated where the signal was coming from when it was pressed at the bedside.

Rationale and Summary

During an observation as part of this Proactive Compliance Inspection (PCI), the call bell in a resident's room was noted to be not working when it was pressed by Inspector #751. The light outside of the resident's room did not light up and no sound was made to alert the nursing staff to indicate where the call bell was coming from.

The Personal Support Worker (PSW) confirmed that the call bell was not working and stated they would inform the maintenance staff. The call bell was replaced by maintenance staff on the same day.

There was a risk to the resident's safety when the call bell system was not functioning properly.

Sources: Observations, Interview with staff.
[751]

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that procedures were developed and implemented to ensure that all residents' rooms call bells were kept in good repair.

Rationale and Summary

During an observation as part of this PCI, the call bell in a resident's room was noted to be not working when it was pressed by Inspector #751. The PSW confirmed that the call bell was not working and stated they would inform the maintenance staff.

The home's Director of Property & Environmental Services (DOPES) indicated that the call bells in the common areas were being checked routinely to ensure they were in good working condition, however checking all the call bells in residents' rooms was not part of this routine checks.

The DOPES provided a new and revised version of a maintenance work order which included monthly checks of all the call bells in residents' rooms.

There was a risk to the safety of the residents when the call bell system in the residents' rooms was not being checked on a regular basis.

Sources: Observations, interview with the home's Director of Property & Environmental Services, review of the home's work order sheet titled "Task #28580005".
[751]

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)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift the symptoms were recorded, and that immediate action was taken to reduce transmission for the resident.

Rationale and Summary

An infection prevention and control (IPAC) checklist was completed as part of the home's PCI.

The resident began to exhibit symptoms indicative of an infection and was later diagnosed with an infection requiring additional precaution.

The home's policy on reporting infection indicated that the nursing staff was to document the resident's infection symptoms in their electronic progress notes.

The resident's electronic progress notes did not record their infection status on several shifts during an identified time period.

As per the IPAC Lead, the registered staff were expected to document resident's infection status on every shift in their electronic progress notes until they have recovered.

The lack of documentation during the specified time period might have affected the interprofessional team's understanding of the resident's health condition.

Sources: The resident's electronic progress notes, home's policy titled "Reporting Infection" last reviewed September 2023, and interview with the IPAC Lead.
[529]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee failed to ensure that the residents' controlled drugs were stored in a separate locked area within the locked medication cart.

Rationale and Summary

Medication administration process was observed as part of this PCI. Upon observing a medication cart, Inspector #751 noted multiple medications were placed in different medication cups within the medication bins for several residents.

The Registered Practical Nurse (RPN) confirmed that the medications were controlled drugs and they had pre-poured them prior to their administration. The Assistance Director of Care (ADOC) confirmed that this was not an acceptable practice.

Failing to ensure the controlled drugs remained in a separate locked area within the medication cart prior to administration would put the residents at risk of receiving wrong medications and dosages.

Sources: Observation, the resident's clinical records, interviews with the RPN and the ADOC.
[751]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that at least one employee of the licensee who

has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52 was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the home's meeting minutes for the CQI, titled as "Professional Advisory Committee (PAC)" for years 2023, and 2024, indicated that a PSW was not in attendance. The Administrator confirmed that the home's CQI committee did not consistently include a PSW.

By failing to include a PSW in the CQI committee, the opportunity for their input related to residents' care was lost.

Sources: The home's Professional Advisory committee (PAC) meeting minutes, and interview with the Administrator.
[751]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that the home published a report on their CQI initiative on its website.

Rationale and Summary

A review of the home's website and an interview with the Administrator both confirmed the home's website was not revised to include their CQI initiative report.

By failing to post the CQI initiative report on the website, the opportunity to share information to outside stakeholders was lost.

Sources: The home's website, and an interview with the Administrator.
[751]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (a)
Continuous quality improvement initiative report
s. 168 (6) The interim report prepared under subsection (5) must,
(a) be published on the home's website, subject to section 271;

The licensee has failed to ensure that the home's CQI interim Report for the 2022-2023 fiscal year was published on the home's website.

Rationale and Summary

A review of the home's website and an interview with the Administrator both confirmed the home's website was not revised to include their Interim CQI report dated 2022-2023.

By failing to post the interim CQI initiative report on the website, the opportunity to share information to outside stakeholders was lost.

Sources: The home's CQI report titled" Parkview Home Continuous Quality Improvement Report 2022/2023", the home's website, and interview with the Administrator.
[751]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents must have received annual training in fall prevention and management in 2023.

Rationale and Summary

A PCI was completed at the Long-Term Care Home (LTCH).

The home's policy on Falls Prevention Program stated that the direct care staff were to receive their training of the program on an annual basis.

The 2023, training records indicated multiple PSWs and registered nursing staff did not complete their annual training of the fall prevention and management program.

The Director of Clinical Operations (DOCO) asserted that the direct care staff were expected to have completed their annual training of the fall prevention and management program via an online learning platform by the end of 2023.

There was a potential risk and impact to the residents as direct care staff might not have provided care and services based on the 2023 training materials.

Sources: The home's policy titled "Falls Prevention Program" last reviewed March 2023, 2023 direct care staff training records, and interview with the DOCO.
[529]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents must have received annual training in skin and wound care in 2023.

Rationale and Summary

A PCI was completed at the LTCH.

The home's policy on Skin and Wound Care Program stated that the direct care staff were to receive their training of the program on an annual basis.

The 2023, training records indicated multiple PSWs and registered nursing staff did not complete their annual training of the skin and wound care program.

The DOCO asserted that the direct care staff were expected to have completed their annual training of the skin and wound care program via an online learning

platform by the end of 2023.

There was a potential risk and impact to the residents as direct care staff might not have provided care and services based on the 2023 training materials.

Sources: The home's policy titled "Skin and Wound Care Program" last reviewed March 2022, 2023 direct care staff training records, and interview with the DOCO. [529]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that all staff who provided direct care to residents must receive annual training in pain management.

Rationale and Summary

A PCI was completed at the LTCH.

The home's policy on Pain Management Program stated that direct care staff were to receive their training on pain management on an annual basis.

The 2023, training records did not contain pain management as a mandatory training topic for the direct care staff. The DOCO confirmed that no direct care staff

had received their annual training in pain management program as it was not included as a mandatory training topic. The DOCO asserted that such topic would be included in the 2024 annual training for the direct care staff.

There was a potential risk and impact to the residents as direct care staff might not have provided care and services based on the 2023 training materials.

Sources: The home's policy titled "Pain Management Program" last reviewed January 2021, 2023 direct care staff training records, and interview with the DOCO. [529]

WRITTEN NOTIFICATION: Visitor policy

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (2) (a)
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;

The licensee has failed to ensure that the home's visitor logs did not contain contact information of the visitors.

Rationale and Summary

A PCI was completed at the LTCH.

Upon entering the LTCH the inspector was required to sign-in to the home's visitor log placed in a binder. The log, however, did not ask for visitor's contact information.

A review of the home's Visitor Policy indicated that visitors must sign in with their contact information when visiting the LTCH.

As per the IPAC Lead, the LTCH was utilizing an electronic visitor sign-in in the past where visitors were required to enter their contact information but later changed to a paper sign-in via the Visitor Log. The IPAC Lead confirmed that the current Visitor Log did not require the visitors to provide their contact information.

There was a potential risk and impact to the residents as the home might not be able to contact the visitors should they need to be contacted in the future.

Sources: Observations, the home's policy titled "Visitor Policy" last reviewed October 2023, and an interview with the IPAC Lead.
[529]