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: May 23, 2024	
Inspection Number: 2024-1451-0002	
Inspection Type: Complaint Critical Incident	
Licensee: The Mennonite Home Association of York County	
Long Term Care Home and City: Parkview Home Long-Term Care, Stouffville	
Lead Inspector Deborah Nazareth (741745)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, May 1, 2, 6, 7, 8, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Two intakes related to an outbreak of disease of public health significance.
- One intake related to falls prevention and management.

The following intake was inspected in this complaint inspection:

- One complaint related to Infection Prevention and Control (IPAC), medication administration, and staffing.

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

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. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure communication of the seven-day menu to residents.

Rationale and Summary

As reported by the Director of Nutritional Services, the Long-Term Care Home (LTCH) communicated the seven-day and daily menus to residents by posting the menus on a board next to each Resident Home Area's (RHA) dining rooms.

During initial observations in the LTCH, four out of five RHAs were found to not have posted communication of the seven-day menu for the specified week.

Multiple Dietary Aides and the Director of Nutritional Services reported that the evening dietary aide is responsible to change the daily menu as well as the seven-day menu on Sundays.

There was no risk to the residents because of the seven-day menu not being communicated. However, residents were unable to view upcoming meals to plan for their week.

Before the conclusion of the inspection the LTCH posted the correct seven-day menu for the residents.

Sources: Observations, interviews with Director of Nutritional Services and others. [741745]

Date Remedy Implemented: May 6, 2024

WRITTEN NOTIFICATION: Food production

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 78 (2) (f)

Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that communication was provided to residents and staff of a menu substitution.

Rationale and Summary

During a dining observation on one RHA, the posted daily menu indicated the dessert options for lunch were fresh seasonal fruit and cappuccino mousse. When staff began to serve dessert, the residents were offered cantaloupe and Jell-O.

The Dietary Aide (DA) reported that when the dessert for lunch was being prepared in the morning, they noted that there were not enough servings of the cappuccino mousse. They asked the cook for a substitution and were informed to provide Jell-O instead. The DA did not update the posted daily menu to reflect the substitution.

The Director of Nutritional Services confirmed that menu substitutions needed to be communicated to the residents and staff and documented.

The menu substitution was not communicated to the residents, however, there was no risk to the residents.

Sources: Observations, daily menu, interviews with staff. [741745]

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)
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 ensure that Routine Practices were followed in the Infection Prevention and Control (IPAC) program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Requirement 9.1 under the IPAC Standard, directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, section 9.1 (d) for Routine Practices shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Specifically, the licensee did not ensure that a Personal Support Worker (PSW) applied appropriate application and removal of PPE.

Rationale and Summary

The LTCH was not experiencing an outbreak during this inspection and mandatory masking was not in place. Staff were expected to conduct a risk-based assessment prior to selecting and applying PPE. During a dining observation, a PSW was

observed in the dining room wearing a piece of PPE that was not covering the intended specified area. The PSW was interacting with residents and other staff in the dining room with their PPE positioned incorrectly for approximately 30 minutes.

The PSW reported that they forgot to remove the PPE after use, and they acknowledged that the PPE was not applied appropriately. The IPAC Lead confirmed that the way the PSW wore their PPE was an inappropriate application of PPE.

When the PSW failed to appropriately apply and remove their PPE there was potential risk for spreading infection.

Sources: Observations, interviews with PSW and the IPAC Lead. [741745]

WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the home's written policies and protocols for the medication management system were implemented.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure the policies developed for the medication management system are complied with. Specifically, the licensee failed to ensure that a Registered Practical Nurse (RPN) complied with their policy, "Medication Administration", RC-12-15, last approved 03/2023, when they administered medication to two residents.

Rationale and Summary

A complaint was received related to medication administration. During a scheduled medication administration at 1200 hours (hrs), an RPN was observed administering medication on an RHA. A visitor approached the RPN and inquired about a scheduled supplement for a resident stating that they had not received it yet. The RPN dispensed the supplement without reviewing the order in the electronic Medication Administration Record (eMAR) and gave it to the visitor. Upon review of the eMAR for the resident, the scheduled supplement was already signed as administered prior to being dispensed by the RPN. Another resident was observed taking their medication by themselves in the dining room at the end of their meal. The RPN was present in the dining room at the time but was not within the immediate vicinity of the resident when they were taking their medication. Review of the eMAR revealed that the resident's medication was already signed as administered before the resident ingested their medication.

The RPN reported that the eMAR is used to guide medication administration. The RPN admitted that they reviewed the resident's orders earlier in their shift and dispensed based on what they remember was ordered at 1200 hrs instead of checking the eMAR. They acknowledged they signed the eMAR before administrating the medications to both residents and that they should sign the eMAR after the medication was administered to the residents. The Director of Care (DOC) confirmed that nurses are required to complete checks before administering

medications and supplements and should sign as administered immediately following administering to the resident. The DOC acknowledged that there was a risk the resident may miss their medication when the nurse signs as administered before actually administering to the resident.

As a result of the RPN's actions, there was a risk of inaccurate administration of medication to the residents.

Sources: Observations, residents' eMAR, LTCH policy "Medication Administration", interviews with RPN and DOC. [741745]