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: September 17, 2024

Inspection Number: 2024-1451-0004

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	**Inspector Digital Signature**
The Inspector	

Additional Inspector(s)
The Inspector

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21 -22, 26, 27 -29, 2024

The inspection occurred offsite on the following date(s): August 27, 28, 2024

The following intake(s) were inspected:

- An intake related to LTCH Complaint
- An intake related to a fall
- An intake related to outbreak

The following intakes were completed in this inspection:

- An intake related to fall incident

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

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

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

During two observations in a specified home area, the tub room door was observed not completely closed and was unlocked. Inside the unlocked room was observed medical equipment, sharps containers and a towel warmer with a temperature reading of 178 degrees Fahrenheit.

The ADOC acknowledged that it was the expectation of the home that the doors for tub and shower areas are to be kept closed and locked at all times, and indicated there may be a problem with the door clicking shut when closed by staff, and that

they would request Maintenance to repair it.

Failing to ensure the tub room was kept closed and locked posed a safety risk to residents that residents could access medical equipment and supplies.

Sources: Observations in the home, interview with ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary

A CIR was received by the Director for a fall with injury for a resident. The resident's care plan identified them as a high risk for falls. According to the resident's care plan for falls prevention, specific interventions were identified to be in place.

On multiple occasions throughout the inspection, the Inspector observed the resident sitting in their designated eating area outside of meals times.

Staff confirmed the identified interventions were not in place and staff were not following the written plan of care for falls prevention.

On a specified date, the Inspector observed the resident sitting in their designated eating spot for the day. The ADOC and BSO nurse confirmed the resident sitting in the dining room for most of the day was not appropriate.

A staff member confirmed they don't follow the interventions in the written plan of care for the resident due to being short staffed and the required equipment being unavailable. Staff confirmed the resident's daily routine was to be placed into the dining room between meals to watch television. Furthermore, family confirmed a concern with the lack of occurring activities for residents.

Failure to implement the plan of care for a resident puts their safety and resident rights at risk.

Sources: Observations, interview with staff and review of the homes Continence policy.

WRITTEN NOTIFICATION: Dress

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.
The Licensee has failed to ensure that a resident was dressed appropriately and suitable to the time of day.

Rationale and Summary

An Inspector observed multiple residents sitting in the dining room outside of meals times wearing aprons.

At 10:00 a.m., staff confirmed residents were sitting in the dining room with aprons on because the unit was short staffed, and residents were placed in the dining room to wait for lunch. Staff indicated residents were wearing aprons because the residents' drool.

ADOC confirmed it was not appropriate for residents to be wearing aprons outside of mealtimes, unless specified by the care plan.

Failure to dress residents appropriately for the time of day put their dignity and rights at risk.

Sources: Observations, plan of care and interview with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
The licensee has failed to ensure cleaning and disinfecting of shower chairs with at minimum a low-level disinfectant.

Rationale and Summary

During an onsite inspection an Inspector observed staff pick up soiled linens off the floor in the unit shower room. The Inspector asked staff what their process was for cleaning the communal shower chair. PSW replied they used a disposal dry nap and add some hand sanitizer from the dispenser to clean the communal shower chair.

Staff confirmed the homes expectation was to use Oxivir wipes to clean shower chairs but there was none available in the shower room. ESM confirmed the homes expectation was to clean shower chairs using Oxivir wipes.

The homes IPAC cleaning and disinfecting policy indicates cleaning and disinfecting of shower chairs using at minimum a low-level disinfectant.

Failure to clean shower chairs appropriately put residents at risk for transmission of infection.

Sources: Observations, Interview with staff and review of homes IPAC cleaning and disinfecting policy.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) The ESM and IPAC Lead are to install hand sanitizer dispensers so that all staff can achieve the four moments of hand hygiene in resident rooms including but not limited to the point of care.
a) The IPAC Lead and or trained designate is to provide in-person education to all staff on the four moments of hand hygiene.
b) The IPAC Lead is to complete hand hygiene (HH) audits, in each home area, daily for 3 weeks, specifically observing the four moments of HH. Audits must include additional precaution rooms if applicable.
Keep a documented record of the education provided, who received the education, the individual who provided the education, the education completion date, and the contents of the education and training materials.
Make these records available to the inspector immediately upon request.

Grounds
The licensee failed to provide hand hygiene to all residents before meals and snacks.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 10.2 (c) states that the licensee shall also ensure that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

Rationale and Summary

A complaint was submitted to the Director related to infection control practices.

During a lunch hour observation in the dining room on a specified unit there was no observations of any staff assisting residents to perform hand hygiene before their meal.

A resident indicated they were not offered or assisted any hand hygiene prior to being served their meal. Staff indicated that the staff are expected to assist residents with hand hygiene and did not. Staff indicated staff usually do hand hygiene for the residents but that today was mostly agency staff and only one staff was regular Parkview staff, and also that the staff were running late.

The IPAC Lead acknowledged it is the expectation of the home that staff to assist residents with Hand hygiene before meals and snacks.

Failing to assist residents with hand hygiene prior before their meal posed a risk of infection to residents of the home.

Sources: Observations, Interviews of resident and staff.

2. The licensee has failed to provide a hand hygiene program which includes at a minimum access to hand hygiene agents at the point-of-care.
In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 10.1 states the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). More specifically, ABHR shall be easily accessible at both point-of care and in other common resident areas, and any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration.

Rationale and Summary

During an onsite inspection, the Inspector observed staff enter a resident room and use the hand sanitizer located inside the resident room located on the wall between the bathroom and the exit. Staff confirmed there is only one hand sanitizer dispenser in the resident room.

IPAC Lead and ESM were asked by the Inspector about how the home was achieving the four moments of hand hygiene. ESM confirmed staff are to use care carts with hand sanitizing product on them when providing care. Staff confirmed they do not use care carts to provide care to residents. Staff confirmed there is no ABHR at the point of care.

Throughout the inspection, the inspector did not observe any care carts being used on the units. Hand Sanitizer was not observed in resident rooms at the point of care.

Failure to provide ABHR at the point of care put residents at risk for infection.

Sources: Observations, interviews with staff and review of the homes policy Hygiene and Grooming.

This order must be complied with by November 8, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.