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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Public Report

Report Issue Date: January 27, 2025
Inspection Number: 2025-1451-0001
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 - 24, 2025

The following intake(s) were inspected:

- One intake was related to a complaint about laundry service and restorative care.
- One intake was related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and response system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
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,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the resident-staff communication and response system was easily accessible for a resident. A resident that was at risk for falls was observed with their communication and response system device out of their reach.

Sources: Observations, interviews with Resource Nurse and others.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure the implementation of a fall intervention device for a resident. A resident who was at risk for falls and utilized a specific device in their room as part of their fall prevention interventions. The device was expected to be placed in a specific area for effectiveness. During an observation the device was not

in the location specified in the care plan. The Resource Nurse confirmed the device should have been placed in the specified location.

Sources: Observations, resident's care plan, interviews with Resource Nurse and others.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident received a skin assessment upon return from the hospital. A resident had an incident and went to the hospital where they were confirmed to have multiple injuries. The resident was at risk of altered skin integrity. There was no documented skin assessment upon return from the hospital. The Resource Nurse acknowledged that an assessment should have been completed by staff.

Sources: Critical Incident Report (CIR), resident's clinical records, interviews with Resource Nurse and others.