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

Public Report

Report Issue Date: August 15, 2025

Inspection Number: 2025-1451-0005

Inspection Type:
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): August 7-8 and 11-15, 2025

The following intake(s) were inspected:
-An intake related to an alleged abuse
-An intake related to a fall with injury
-An intake related to an injury of unknown origin
-An intake related to a fall with injury

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

The Licensee failed to ensure that the falls prevention equipment that staff use for a resident, under the Falls Prevention and Management Program, were appropriate for the resident and based upon their condition.

The resident's plan of care outlined instructions for the use of specific equipment related to falls prevention. The resident did not have the equipment in place during an observation. The home's Resource Nurse/Falls Lead acknowledged that the equipment may not be effective for the resident. Evaluation of the appropriateness/effectiveness of the equipment has not taken place and alternative interventions have not been considered.

Sources: Observation, health records for a resident, and interviews with staff.

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 failed to comply with the home's Falls Prevention and Management Program when strategies to reduce or mitigate falls, including the implementation of fall prevention related equipment, were not implemented in accordance with a resident's assessed fall risk on a specific date.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Falls Prevention and Management Program were complied with.

Specifically, the home's Fall Prevention Program Policy indicated that each resident assessed as high risk for falls will have a resident centered interdisciplinary care plan with interventions to reduce falls and mitigate complications from falls.

A resident was assessed to be a certain level of risk for falls on a specific date, however, no falls interventions indicated for a resident of that risk level for falls were implemented. The home's Resource Nurse/Falls Lead acknowledged that more interventions should have been implemented following the resident's assessment as well as after they sustained an unwitnessed fall on certain date, but were not.

Sources: Health records for a resident, the home's Fall Prevention Program Policy, and interviews with staff.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112
Licensees who report investigations under s. 27 (2) of Act
s. 112.
(1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person

or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
(2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.
(3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to make a written report to the Director, required under subsection 27 (2) of the Act, that included a description of the incident, a description of the individuals involved in the incident, actions taken in response to the incident, as well as analysis and follow-up action in relation to an alleged/suspected incident of abuse of a resident by another resident on a specific date. A resident to resident interaction occurred and a staff member reported the suspected/alleged abuse through the After Hours Line. The home's Director of Care (DOC) indicated that a Critical Incident Report (CIR) was not required as the resident's injury was determined to have been acquired prior to the interaction.

Sources: After Hours Report and interview with the home's DOC.

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