Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 23, 2015 | 2015_240506_0023 | H-003490-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

PARKVIEW HEALTH CARE PARTNERSHIP (THE)
284 SUNSET DRIVE OAKVILLE ON L6L 3M4

### Long-Term Care Home/Foyer de soins de longue durée

PARKVIEW NURSING CENTRE
545 KING STREET WEST HAMILTON ON L8P 1C1

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LESLEY EDWARDS (506), CAROL POLCZ (156), MELODY GRAY (123)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): November 3, 4, 5, 6 and 9, 2015.**

**During this inspection the inspections listed below were conducted concurrently:**
**Complaints**
**H-001754-14 - related to the administration of medications, residents' rights and abuse.**
**H-001836-15 - related to resident's rights, pain management and plan of care.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument Co-ordinator (RAI),registered nursing staff, personal support workers (PSW's), Program Manager, maintenance staff, dietary staff, families and residents.**

**During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**10 WN(s)**
**3 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the rights of residents were fully respected and promoted specifically to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date in November 2015, the medication pass was observed. The garbage of the medication cart was noted to have opened medication pouches which contained resident's names and the names of medications which were included in the pouches. Registered staff #111 was observed administering medications to a number of residents. They confirmed the process of discarding the pouches into the garbage and identified that it would later be disposed of with the regular garbage. The home did not fully respect the rights of residents as their personal health information was being discarded into the regular garbage. [s. 3. (1) 11.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents rights were fully respected and promoted and specifically to have their personal health information kept confidential, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

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

A. On an identified date in November 2015, the doors to the laundry chutes located on the resident home areas, on the second, third and fourth floors were noted to be unlocked and without locking mechanisms. The DOC was made aware of the concern and confirmed that the doors doors did not have locks.

B. On an identified date in November 15, the door to room #215 was noted to be difficult to open and would not close properly. The door arm at the top inside of the room door was missing and the door handle was loose. The Maintenance staff confirmed that the door was broken and was not safe. [s. 5.] (123)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's environment is safe and secure for its residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

According to the clinical record, resident #040 made verbal expressions of pain on identified dates in December 2015, related to the resident having a stage II pressure ulcer and an infection. The RAI co-ordinator confirmed the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose, when the resident's pain was not relieved. [s. 52. (2)] (506)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a residents pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the policy and procedure for pain management was complied with.

The home's policy "Resident Services Manual, Pain Management" (policy number section: 4.14, last revised 04/15) indicated that when a resident has presence of pain either by verbal complaint or observation of behaviour change or condition change including acute illnesses and end of life care to complete a pain screening tool and complete a pain assessment within 24 hours.

A. During a review of resident #040's clinical record it was noted that the resident did not receive a pain screening tool or a pain assessment when the resident made verbal expressions of pain on identified dates in December 2015. This was confirmed through record review and the DOC confirmed that pain screening assessments were not completed at this time. [s. 8. (1) (b)]

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, (a) the home, furnishings and equipment were kept clean and sanitary.

On an identified date in November 2015, during the initial tour of the home, it was observed that:
i. Six chairs in the fourth floor dining area/sitting area were stained and soiled.
ii. Three chairs in the third floor dining area/sitting area were all stained and soiled.
iii. Three chairs in the second floor dining area/sitting area were all stained and soiled.
iv. In the main dining room on the first floor more than half the chairs were stained and soiled.
The Maintenance Supervisor confirmed that the homes furnishings were not kept clean and sanitary.[s. 15. (2) (a)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) 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; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal is coming from.

On an identified date in November 2015, the call bell in the second floor shower room and the call bell in the bathroom of room #213, were activated and the lights in the hallway did not turn on. Maintenance staff were interviewed and confirmed that the lights above the doors to indicate where the signal was coming from, were not working as the bulbs were missing and there was a problem with the electrical system. [s. 17. (1) (f)] (123)

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The record of resident #10 was reviewed and the minimum data set resident assessment instrument (MDS-RAI) continence assessment indicated that on admission the resident was continent of urine. Ninety-days after admission the resident's RAI-MDS assessment noted that the resident was occasionally incontinent of urine. An incontinence assessment was not found in the resident's record.

The RAI-MDS coordinator was interviewed and confirmed that the resident's urinary continence changed ninety-days after admission and that an assessment using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence was not completed.

B. The record of resident #005 was reviewed and the MDS-RAI continence assessment indicated that on admission the resident was assessed as being occasionally incontinent of urine. Ninety-days after admission the resident's RAI-MDS bladder assessment noted that the resident was frequently incontinent of urine. Documentation of an assessment done at the time of the change in the resident's continence assessment, was not found in the resident's record.

The RAI-MDS coordinator was interviewed and confirmed that the resident's urinary continence changed ninety-days after admission and that an assessment using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence was not completed. [s. 51. (2) (a)] (123)

2. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

A. The record of resident #10 was reviewed and it was noted that ninety-days after admission the resident was assessed as being occasionally incontinent of bladder. The resident's plan of care was reviewed and it was noted that the resident was continent of bladder. The RAI-MDS Coordinator was interviewed and confirmed that the resident's plan of care to promote and manage bladder continence was not based on the assessment.

B. The record of resident #005 was reviewed and the resident's RAI-MDS bladder continence assessment indicated that ninety-days after admission the resident was

assessed as being frequently incontinent of bladder. The resident's plan of care was reviewed and it noted that the resident was occasionally incontinent of bladder. The RAI-MDS Coordinator was interviewed and they confirmed that the resident's plan of care to promote and manage bladder continence was not
based on the assessment. [s. 51. (2) (b)] (123)

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

On an identified date in November 2015, on the fourth floor, the planned menu items for dessert were oranges or peanut butter cookie. Five out of six residents residents were not offered the planned menu as there was only one portion of peanut butter cookie available and the remaining dessert was oranges . Five residents did not have a choice of dessert as only the fruit was available. The planned menu items for dessert were not offered and available. [s. 71. (4)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

On an identified date in November 15, the hot water tap in the bathroom of resident #009 was observed to be in the off position but a steady stream of hot water was flowing from the tap. The tap could not be turned off. Maintenance staff confirmed that the hot water tap was broken and needed to be repaired. [s. 90. (2) (d)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff participate in the implementation of the program.

On an identified date in November 2015, during the tour of the home, two used and unlabeled white urinal hats were left in the shared bathroom. Non-registered staff #110 was interviewed and they confirmed that the urine hats were used and that it was the home's expectation that the white urinal hats were to be used once and then thrown away and were not to be left in the residents' bathroom. [s. 229. (4)]

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**Issued on this 24th day of November, 2015**

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| **Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**