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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 04, 2019	2019_570528_0001 (A1)	018632-17, 025303-17, 027688-17, 025970-18	Critical Incident System

Licensee/Titulaire de permis

The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner
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

Amended by CYNTHIA DITOMASSO (528) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue

Ministry of Health and Long-Term Care

Ontario

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

sous *la Loi de 2007 sur les foyers de soins de longue durée*

This report has been revised to reflect a review of Compliance Order (CO) #001. Order CO #001 was rescinded and substituted with a Voluntary Plan of Correction (VPC).

Issued on this 4 th day of March, 2019 (A1)

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

Original report signed by the inspector.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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Mar 04, 2019	2019_570528_0001 (A1)	018632-17, 025303-17, 027688-17, 025970-18	Critical Incident System

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Parkview Nursing Centre
545 King Street West HAMILTON ON L8P 1C1

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

Amended by CYNTHIA DITOMASSO (528) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 3, 4, 7, 2019.

This critical incident inspection included log #'s:

i. 018632-17 related to falls prevention

ii. 025970-18 related to resident altercation

iii. 027688-17 related to resident to resident altercation and fall prevention

iv. 025303-17 related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector(s): observed the provision of care, reviewed documents, including but not limited to: medical records, complaint records, policies and procedures, staff schedules, interviewed residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Responsive Behaviours

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

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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.) Ce qui suit constitue un avis écrit de nonrespect 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. 19. Duty to protect
Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

Critical Incident #2700-000012-18, log # 088204-18, submitted in September 2018, described an altercation between resident #003 and resident #004 causing injury to resident #004.

i. Review of the medical records for resident #003, identified that the resident had a history of responsive behaviours towards staff and co-residents; was being followed by additional resources. An assessment prior to the incident in September 2018, outlined that the resident's behaviours were unpredictable and advised staff to use their specified emergency response. Monthly responsive behaviour meeting minutes and progress notes, that same month, outlined that the resident continued to display responsive behaviours and summarized interventions to assess and monitor the behaviour. ii. Review of incident reports and progress notes documented, that on an identified day in September 2018, resident #003 began to display responsive behaviours. Interview with RPN #105 during the course of the inspection, revealed that resident #003 demonstrated responsive behaviours towards several staff. In the interview RPN #105 reported that the staff provided interventions, as required in the plan of care. In the interview with RPN #105, it was identified that resident #003 proceeded to resident #004 while staff observed the resident. They described that resident #003 proceeded to display responsive behaviours towards resident #004, at which time, staff intervened. iii. Review of the home's emergency policy for "Violent Individuals", revised March 2018, directed staff to complete the following : 1. When an individual is displaying violent behaviours or risk of violence, staff should ensure that residents and other staff in immediate danger are looked after as much as possible. Staff can attempt to diffuse the situation if it is safe to do so.

2. Remove residents in immediate danger and attempt to isolate the person causing the situation.

3. If the staff cannot diffuse the situation and require charge personnel to assist; one staff will be assigned to call the charge RN on their extension

iv. Interview with RPN #105 revealed that they could not remember who called the RN for assistance but at an unidentified time, the RN was called for assistance. Interview with RN #104 confirmed that, at an unidentified time, they were called to the nursing home area to assess the resident and that when they arrived resident #003 was approaching resident #004, and that staff were observing the resident but not with the resident. Interview with RN #104 and the DOC confirmed resident #004 was injured during the incident. Interview with the Administrator, confirmed that on an identified day in September 2018, the RN was called to the floor, according to the home's 'Violent Individuals' emergency plan; however, resident #004 sustained injuries as a result of the altercation.
v. Review of the progress notes from resident #003 identified that in the days prior to the incident, they had an altercation with a co-resident and when staff intervened, the resident displayed responsive behaviours towards staff. vi. Interviews with PSW #106, #110, RN #104 and RPN #105 did not identify any interventions that were put in place to protect resident #004 from resident #003, until after the altercation.
As a result of the altercation in September 2018, resident #004 sustained injuries. Resident #004 was not protected from physical abuse by resident #003. [s. 19. (1)]

Additional Required Actions:

(A1)

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 residents are protected from abuse by anyone, to be implemented voluntarily.

The following order(s) have been rescinded: CO# 001

WN #2: 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 the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Critical Incident #2700-000012-17, log # 025303-17, submitted in October 2017, identified that resident #001 sustained an injury causing significant change.

i. The home's policy provided to the LTC Homes Inspector '4.14 Pain Management', last revised June 2018, was effective at the time of the incident, as confirmed by the DOC. The policy identified that residents were to have pain assessments completed on admission, readmission, quarterly and when pain was indicated by a verbal complaint or observation change or condition change. Specifically, the registered staff member was to assess the resident and complete a pain assessment in Point Click Care (PCC) and enter a progress note titled "pain management" in PCC.

ii. Review of the medical records for resident #001 revealed that they had a fall in October 2017, a progress note documented that the resident had a change in status. The following day, the resident was documented as having a change in status and was sent out for assessment. Review of PCC did not include pain assessments on the days when the resident was documented as having a change in status, including pain. Interview with the registered staff #107 during the course of the inspection, confirmed that on the identified days, resident #001 did not have completed pain assessments in PCC, as required in the 'Pain Management' policy. (528) [s. 52. (2)]

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 the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours
Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :
1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.
Critical Incident #2700-000012-18, log # 088204-18, submitted in September 2018, described an altercation between resident #003 and resident #004, causing injury to resident #004.

i. Review of the medical records for resident #003, identified that the resident had a history of responsive behaviours; was being followed by additional resources. An assessment prior to the incident in September 2018, outlined the resident's behaviours and advised staff to use their emergency response for violent persons. Monthly responsive behaviour meeting minutes and progress

notes, that same month, outlined that the resident continued to display responsive behaviours and summarized interventions to assess and monitor the behaviour.

ii. Review of risk management report, identified that in September 2018, resident #003 began to display responsive beahviours after an interaction with staff. Interview with PSW #110 confirmed that they were present when the interaction occurred between staff and resident #003. PSW #110 identified that the staff member did not implement an intervention, as required in the plan of care. Interview with PSW #106, #110 and RPN #105 confirmed that after the incident, the resident demonstrated responsive behaviours.

On the identified day in September 2018, the staff did not implement the specified intervention towards resident #003.[s. 53. (4) (b)]

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 strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The plan of care for resident #002, identified that they had a fall in June 2017, resulting in injury and was sent for assessment. The resident returned to the home the following day with an injury and new medication orders. Review of the electronic medication administration record (eMAR) revealed that new medication was ineffective on several occasions. On the third day, the physician ordered an additional medication.

The homes pain policy 'Pain Management, 4:14, last revised June 2018, was provided to the LTC Homes Inspector, and in an interview with the DOC confirmed that it was effective at the time of the incident. The policy directed staff that when a new pharmacological intervention was ordered, a dosage or interval change was made for pain management, the pain assessment monitoring record should have been implemented. The policy defined the pain assessment monitoring record as a paper copy that was to be placed in the narcotic binder. However, review of the plan of care did not include a completed pain assessment monitoring record related to the change in pain medication. Interview with the Administrator confirmed that the effectiveness of the medication was not evaluated, as required. [s. 134. (a)]

Issued on this 4 th day of March, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or of the *Long-Term Homes Act, 2007*, S.O.

Ordre(s) de l'inspecteur

Aux termes de l'article 153 section 154 et/ou de l'article 154 de la *Loi Care de 2007 sur les foyers de soins de longue durée*,

Long-Term Care Homes Division
Long-Term Care Inspections Branch Division
des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Amended by CYNTHIA DITOMASSO (528) - (A1)
Nom de l'inspecteur (No):

Inspection No. / No de l'inspection :	2019_570528_0001 (A1)
Appeal/Dir# / Appel/Dir#:	018632-17, 025303-17, 027688-17, 025970-18 (A1)
Log No. / No de registre :	Critical Incident System
Type of Inspection / Genre d'inspection:	Mar 04, 2019(A1)
Report Date(s) / Date(s) du Rapport:	
Licensee / Titulaire de permis :	The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner 284 Sunset Drive, OAKVILLE, ON, L6L-3M4
LTC Home / Foyer de SLD :	Parkview Nursing Centre 545 King Street West, HAMILTON, ON, L8P-1C1

Ministry of Health and Long-Term Care / **Ministère de la Santé et des Soins de longue durée**

Order(s) of the Inspector / Ordre(s) de l'inspecteur

Pursuant to section 153 and/or of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 section 154 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice de l'administrateur : Lisa Hiscott

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To The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

(A1)
The following Order(s) have been rescinded:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director

Pursuant to section 153 and/or of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 section 154 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both: Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

2007, c. 8 L. O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Ministry of Health and Long-Term Care / **Ministère de la Santé et des Soins de longue durée**

Order(s) of the Inspector / Ordre(s) de l'inspecteur

Pursuant to section 153 and/or of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 / Aux termes de l'article 153 section 154 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à : la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4 th day of March, 2019 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by CYNTHIA DITOMASSO (528) - (A1)

Service Area Office / Bureau régional de services : Hamilton Service Area Office