Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 19, 2023	
Original Report Issue Date: May 31, 2023	
Inspection Number: 2023-1199-0002 (A1)	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner	
Long Term Care Home and City: Parkview Nursing Centre, Hamilton	
Amended By Sydney Withers (740735)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This licensee report has been revised to reflect a change in the content and legislative reference of non-compliance #006. The legislative reference was changed from O. Reg. 246/22 s. 166 (2) to O. Reg. 246/22 s. 166 (2) 8.

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Lead Inspector	**Additional Inspector(s)**
Sydney Withers (740735)	Lisa Vink (168)
Amended By	**Inspector who Amended Digital Signature**
Sydney Withers (740735)	

AMENDED INSPECTION SUMMARY

This licensee report has been revised to reflect a change in the content and legislative reference of non-compliance #006. The legislative reference was changed from O. Reg. 246/22 s. 166 (2) to O. Reg. 246/22 s. 166 (2) 8.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 16-17, 23-26, 29, 2023

The following intakes were inspected:

- Intake: #00087465 - Proactive Compliance Inspection

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident related to transfer status.

Rationale and Summary
A resident's plan of care identified that staff could provide transfer assistance using two different lifts. A lift logo, which provided direction to staff, was only present at the end of the resident's bed for one of the two lifts listed in the plan of care. Registered staff confirmed that an additional logo was required at the end of the resident's bed, to provide direction to staff.

The additional logo was applied to the bed on May 26, 2023.

Sources: Resident plan of care, resident room observations, and interviews with staff. [168]

Date Remedy Implemented: May 26, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident’s care needs changed and care set out in the plan was no longer necessary related to additional precautions.

Rationale and Summary
The resident's plan of care identified they were colonized for an infection and included the need for specified precautions with care and signage on their door advising visitors to check with the nurse for precautions. Personal protective equipment and signage indicating the required precautions were not available at the resident's bedroom door. Registered staff identified that the resident was now on universal precautions and that more specific precautions were no longer necessary.

Sources: Resident plan of care, resident room observations, and interviews with staff. [168]

Date Remedy Implemented: May 26, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised related to their toileting needs when their care needs changed.

Rationale and Summary
The resident's plan of care identified they required one staff assistance for toileting. An assessment completed in March 2023 noted they required the assistance of two staff for the task. Staff interviews confirmed the resident now required two staff for toileting.

The plan of care was revised on May 17, 2023, to ensure it was reflective of the current care needs of the resident.

Sources: Resident plan of care and interviews with staff. [#168]

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Date Remedy Implemented: May 17, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure the home's nutritional care, dietary services and hydration program was followed, specifically where staff were required to record point of service temperatures of all menu items prior to the commencement of meal service.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a nutritional care, dietary services and hydration program which included the implementation of interventions to mitigate and manage risks within dietary services, and that it was complied with.

Specifically, staff did not comply with the "Point of Service Temperatures" policy.

Rationale and Summary
Point of service temperature records for lunch service on May 16, 2023 were reviewed. There was no temperature documented for the soup on the menu, which was acknowledged by a Dietary Aide (DA) and the Food Service Supervisor (FSS). The FSS stated that the staff member responsible for preparing and taking temperatures of the soup was away that week and a DA was filling in.

The DA acknowledged that their responsibility to take soup temperatures was clarified by the FSS and that it was taken on May 17, 2023. Temperature records for May 17, 2023 were reviewed and it was noted that the soup temperature at lunch service was documented.

Failure to obtain point of service temperatures posed the risk that unsafe temperatures may not have been identified or corrected prior to meal service.

Sources: Kitchen food temperature records (May 16-17, 2023); policy "Point of Service Temperatures" (reviewed February 2022); interviews with staff. [740735]

Date Remedy Implemented: May 17, 2023

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WRITTEN NOTIFICATION: Maintenance Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee has failed to ensure that when the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

Rationale and Summary
A complaint regarding water temperatures resulted in a review of the water temperature log for the month of May. Water temperatures on five shifts were not monitored between May 1-24, 2023, which was acknowledged by a Registered Nurse (RN). The home's policy "Water Temperature" required the charge RN to monitor and document hot water temperatures once per shift.

There was an increased risk of water temperatures outside of the required range being missed when temperatures were not monitored every shift.

Sources: Water temperature log (May 2023); policy "Water Temperature" (reviewed January 2010); interview with RN. [740735]

(A1)
The following non-compliance has been amended: NC #006

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

The licensee has failed to ensure that at least one personal support worker (PSW) was part of the continuous quality improvement (CQI) committee.

Rationale and Summary
In an interview with the Administrator, the designated lead for the home's CQI initiative, they acknowledged that the CQI committee did not include at least one PSW.

Sources: Interview with Administrator. [740735]