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

Hamilton District
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Original Public Report

Report Issue Date: April 9, 2024	
Inspection Number: 2024-1199-0001	
Inspection Type: Critical Incident	
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	
Lead Inspector Leah Curle (585)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 8, 11, 18-19, 21, 2024.

The following Critical Incident intakes were inspected:

00092444 Falls Prevention and Management
00105558 Infection Prevention and Control
00107479 Infection Prevention and Control

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents has a screen and could not be opened more than 15 centimetres (cm).

Rationale and Summary

On March 8, 2024, two windows in resident rooms on the fourth floor of the home were found unsecure.

a) One window in a resident room opened 55 cm and did not have a screen in place. The Maintenance Lead reported an air conditioner was removed from the window on a date in January 2024, at which time, the screen and the latch to prevent the window from opening more than 15 cm was not reinstalled.

The home demonstrated their process to ensure screens and latches were reinstalled when air conditioners were removed; however, confirmed the identified window was missed in error.

The home immediately reinstalled the safety latch and screen for the window system.

b) A second window in another resident room opened 48 cm and had a screen in place. A latch was in the window system; however, the mechanism failed to prevent the window from opening more than 15 cm.

The home immediately fixed the safety latch for the window system.

Sources: observation of windows in two resident rooms on fourth floor, interview with the Maintenance Lead. [585]

Date Remedy Implemented: March 8, 2024

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that when two residents demonstrated symptoms of infection, the symptoms were recorded on every shift.

Rationale and Summary

The licensee was to ensure that on every shift, symptoms indicating the presence of infection were monitored in accordance with any standard or protocol issued by the Director and the symptoms were recorded and immediate action was taken to reduce the transmission, isolate residents, and place in cohorts, as required.

The Infection Prevention and Control (IPAC) Lead reported residents were screened twice daily for symptoms of COVID at 0800 hours and 2000 hours, and when a resident demonstrated symptoms of infection, staff were to document symptoms in a progress note in Point Click Care (PCC) and notify the Registered Nurse (RN).

The IPAC lead acknowledged the home had three nursing shifts in a 24-hour period and there was no record to capture monitoring of the residents symptoms during the night shift.

One resident presented with new symptoms of infection on a date in December 2023. There was no documentation in their clinical record to indicate monitoring of their condition on five consecutive night shifts in December 2023.

A second resident tested positive for an infection on a specified date in January 2024. There was no documentation in their clinical record to indicate monitoring of their condition during two consecutive night shifts in January 2024.

When symptoms indicating the presence of infection are not documented on every shift, this has the potential of not accurately assessing a decline or improvement of the resident's status and/or accurately analyzing the data collected to detect trends.

Sources: progress notes of two residents, eMAR records of two residents from December 2023 and January 2024, interview with the IPAC Lead. [585]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including ensuring that a medication cart containing drugs was locked at all times when not in use.

Rationale and Summary

During the inspection, there were two occasions on the third floor were a medication cart was found unsecure.

a) Keys were observed on top of a medication cart beside the nursing station, and no registered nursing staff was present. A registered nursing staff confirmed the keys were unattended.

b) A key was observed placed in the push lock of the medication cart, with several other keys hanging off the same key ring. Registered nursing staff was absent from the cart for approximately two minutes.

The Director of Care (DOC) reported if a medication cart was not within reach of the nurse, it should be locked at all times and the keys kept in possession of the nurse.

The DOC noted other keys on they key ring included the key for the narcotics bin inside the medication cart; which was to be double locked.

Failure to ensure the drugs in the medication cart were kept locked at all times when the cart was not in use increased risk of unauthorized access to medications or theft.

Sources: observation of unsecure medication cart, interview with a registered nursing staff and the DOC. [585]