Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 11, 12, Jul 6, 2012	2012_027192_0031	Complaint

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care related to H-000863-12.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports and policy and procedure.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

a) Resident 001 was experiencing an exacerbation in behaviours and 1:1 staff was being provided.

b) In 2012 while under 1:1 supervision resident 001 struck resident 002 causing injury. Documentation review and interview confirm that the staff member responsible for 1:1 supervision was on break at the time and that regular staff were to be supervising resident 001, but were not providing direct 1:1 supervision.

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 ensuring that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 subsections:

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 protect residents from abuse by anyone. [s. 19. (1)]

a) In 2012 resident 002 was hit by resident 001 causing injury.

b) Resident 001 was to have been provided 1:1 supervision at the time the incident occurred. Documentation review and interview confirm that the staff member providing 1:1 supervision was on break and the resident was being supervised by the regular staff on the floor at the time of the incident.

c) Resident 001 was known to be experiencing an exacerbation in responsive behaviours and was known to react with aggression in unpredictable situations.

d) Resident 001 had previous aggressive incidents with residents 003 in 2012 in addition to several incidents of physical aggression directed at staff.

The licensee failed to protect resident 002 from abuse by resident 001.

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

Issued on this 13th day of July, 2012

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

Debra Saville (192)