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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2021	2021_911506_0008	018575-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

Parkview Meadows Christian Retirement Village
72 Town Centre Drive Townsend ON N0A 1S0

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

Gardenview Long Term Care Home
72 Town Centre Drive Townsend ON N0A 1S0

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

LESLEY EDWARDS (506), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): November 24, 25, 26, 29, 30 and December 1 and 2, 2021.

During the course of the inspection, the inspector(s) spoke with Corporate Executive Officer/Director of Care (CEO/DOC), Assistant Directors of Care (ADOCs), Controller, Maintenance Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, Program Service Manager, former Program Service Manager, Director of Dietary/Environmental Services, screener, housekeeping staff, residents and families.

During the course of the inspection, the inspectors: toured the home, completed an infection control checklist, observed the provision of care, dining and snack observation, medication administration, reviewed clinical records, reviewed required programs, reviewed relevant policies and procedures, reviewed meeting minutes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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 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 non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice.

A. Resident #002 was scheduled to have their baths on specified dates. Point of Care (POC) documentation was reviewed for bathing for the month of November 2021, and on a specified date in November 2021, there was no documentation that the resident had their scheduled bath.

PSW #118 stated they believed the resident did not have a bath that day due to short staffing.

The Corporate Executive Officer/Director of Care (CEO/DOC) acknowledged that the resident was not bathed twice a week.

Sources: Resident #002's clinical record; interviews with PSW #118 and the CEO/DOC.

B. Resident #018 was scheduled to have their baths on specified dates. A review of POC documentation for bathing for the month of October 2021, noted that the resident was bathed four times, of nine scheduled baths.

The CEO/DOC reported that there was a period of time where the bath shift was pulled due to short staffing. They acknowledged that the resident was not bathed twice a week.

Sources: Resident's clinical record; interviews with PSWs and the CEO/DOC

C. Resident #021 was scheduled to have their baths on specified dates. POC documentation was reviewed for bathing for the month of November 2021, and on a specified date in November 2021, there was no documentation that the resident had their scheduled bath.

PSW #122 stated that they did not provide a bath to the resident on the identified date.

The CEO/DOC acknowledged that the resident was not bathed twice a week.

Sources: Resident #021's clinical record; interviews with PSW #122 and the CEO/DOC.

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 are bathed twice a week by a method of their choice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that residents, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

The home's policy "Skin/Wound Care" policy directed registered staff to complete the weekly wound assessment tool and assess wounds weekly.

A clinical record review was completed for two residents with altered areas of skin integrity and the weekly skin and wound assessments were not completed for the identified residents.

The Registered Nurse (RN) confirmed that weekly wound assessments were not completed for the two residents.

The risk of not completing weekly wound assessments for residents was that staff could not evaluate if the wounds were worsening.

Sources: Resident's skin and wound assessments; interview with RN and the home's policy for Skin/Wound Care policy" (last reviewed July 2019).

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 residents exhibiting altered skin integrity, are reassessed at least weekly by a member of the registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program in relation to resident and staff hand hygiene and use of appropriate personal protective equipment (PPE).

A. The home's policy, "Hand Washing and Use of Alcohol Hand Sanitizer", stated "resident hand hygiene will be performed before eating and/ or drinking and staff hand hygiene before preparing, handling, serving food or feeding a resident and any resident contact.

i. On an identified date in November 2021, a portion of the nourishment pass was observed on a specified floor. A PSW was observed to serve nourishment, assist residents and remove soiled dishes from residents' rooms without performing hand hygiene.
The PSW was also observed to serve residents beverages without providing the residents assistance with hand hygiene.
ii. During a medication pass on a specified date in November 2021, it was observed that the RN completed a treatment on a resident and did not wash their hands. The RN went back to the medication cart which was in a common area, completed documentation and then went and gave another two residents their medications and did not wash their hands between each medication pass.
Interview with the RN confirmed that they should have washed their hands after providing a resident treatment and between each medication pass.

Assistant Director of Care (ADOC) #102 confirmed it was an expectation of staff to offer residents hand hygiene before and after eating as per the policy and to perform hand hygiene before and after feeding a resident and contact with residents such as medication administration.

Not performing hand hygiene when indicated increased the risk of infectious disease transmission.

Sources: the home's policy, "Hand Hygiene and Use of Alcohol Hand Sanitizer, Infection Control Manual"; reviewed September 2021; snack observation; medication pass observation and interviews with staff.

B. The long-term care home’s IPAC program included requirements for staff to wear a gown, gloves, eye protection and a mask when providing direct care or when in contact with items in the resident's environment.

The home was put in an outbreak by Public Health (PH) on a specified date in November 2021, which required residents to be on droplet/contact precautions.

On an identified date in November 2021, a staff member was exiting a resident's room, who required droplet/contact precautions as per the sign on the bedroom door and direction from PH. The staff member was not wearing any PPE other than a surgical mask. The same staff was about to enter another resident's room, which also required droplet/contact precautions without donning appropriate PPE..
The staff member indicated that they had not used all of the required PPE and when they had been in contact with items in the resident's environment.

Not wearing appropriate PPE put the staff member and other residents at risk due to the possible spread of infection.

Sources: Observations of signage and staff not wearing PPE; interview with staff and the homes IPAC program.

C. The home's Contact Precautions and Droplet Precautions policies identified that the appropriate signage was to be placed at the doorway of affected resident rooms. to advise visitors or staff on the appropriate PPE to be applied before entering the room.

On an identified date in November 2021, the Inspector identified two resident rooms with signage for contact and droplet precautions.
A review of the clinical record for resident #012 and #013 who resided in the respective rooms indicated that they required contact precautions only. The ADOC confirmed the incorrect signage was posted.

Lack of appropriate signage outside resident rooms put the residents and staff at risk of spreading infection.

Sources: Contact Transmission Precautions policy, last revised September 2021; Droplet Transmission Precautions policy, last reviewed September 2021; observations of signage and PPE; interview with the ADOC #102.

On a identified date in November 2021, the home went into an outbreak after several residents on the identified floor were demonstrating signs and symptoms of the outbreak. On a specified date in November 2021, the home had not put any signage on the entrance of the home or to the door of the identified unit to identify that the home area was in an outbreak; and this was not in place until four days later as confirmed by the ADOC.

Lack of appropriate signage outside the resident rooms, may have prevented staff and visitors from wearing the required PPE.

Sources: Observations of the entrance of the home and the unit; interview with ADOC #102.

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to the resident related to their diet order.

A resident's written plan of care indicated that they were at a nutritional risk related to specific medical diagnosis. The diet list in the servery did not identify that the resident was on a specific diet, only that they required the specialized diet at a specified time.

On an identified date in November 2021, staff were observed assisting the resident with something that was not on their specified diet, which the Director of Dietary confirmed.

The Director of Dietary stated that the resident only required the specialized diet at a specific time and did not require any other interventions. They acknowledged that the resident's written plan of care should have been updated to reflect their correct diet order and provide clear direction.

Sources: Resident's clinical record; dining observation; interview with the Director of Dietary.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home’s menu cycle,
(f) is reviewed by the Residents’ Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

A review of the Residents' Council meeting minutes did not identify any documentation that the menu cycle was reviewed. The former and current Program Services Managers reported that since July 2021, members of the Residents' Council were not provided the opportunity to review the menu cycle.

Sources: Residents' Council meeting minutes; Interview with the former and current Program Services Managers. [s. 71. (1) (f)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the pureed food was prepared, stored, and served using methods to preserve the appearance and food quality.

On a identified date in November 2021, pureed texture foods served to residents on a specified home area were found to be runny, non-cohesive, and pooled out when plated.

The home's "Diet Order Terminology - Texture" policy indicated that all pureed foods should be smooth and cohesive and that they should not be served if they are thin, runny or lumpy.

Inspector #683 showed a photo of plates from the meal to the Director of Dietary and they acknowledged that the food appeared runny.

Pureed foods that were runny may pose risk to residents who require thickened fluids.

Sources: Dining observation and related photos; "Diet Order Terminology - Texture" policy, dated January 2011; Interview with the Director of Dietary.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Residents' Council reviewed the meal and snack times.

A review of the Residents' Council meeting minutes did not identify any documentation of the meal and snack times being reviewed. The former and current Program Services Managers reported that since July 2021, members of the Residents' Council were not provided the opportunity to review the meal and snack times.

Sources: Residents' Council meeting minutes; Interview with the former and current Program Services Managers. [s. 73. (1) 2.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents and an explanation of whistle-blowing protections related to retaliation were posted.

During a tour of the home on November 24, 2021, the home's policy to promote zero tolerance of abuse and neglect to residents and an explanation of whistle-blowing protections related to retaliation could not be located in a conspicuous and easily accessible areas of the home. ADOC #102 confirmed that this information was not posted anywhere in the home.

Sources: Tour of the home; interview with ADOC #102. [s. 79. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee has failed to ensure that the advice of the Residents' Council and the Family Council was sought out in developing and carrying out the satisfaction survey, and in acting on its results.

The former Program Services Manager reported that they sought the advice of the President of Resident's Council in developing the satisfaction survey prior to sending it out in March 2020 and acknowledged all members of the Council were not provided the opportunity to review the survey. The former and current Program Service Managers acknowledged that the results of the survey were also not shared with Residents' Council.

The President of Family Council stated that their advice was sought out in developing and carrying out the satisfaction survey in 2019, but they did not review the survey prior to it being sent out in March 2021. They also reported that the results of the survey were not shared with them.

The CEO/DOC acknowledged that the results of the survey were not shared with the Family Council.

Sources: Residents' Council meeting minutes; interview with the former and current Program Services Managers and the CEO/DOC. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

The licensee has failed to ensure that the Director was immediately informed, in as much detail regarding an outbreak of a disease of public health significance.

On a identified date in November 2021, the home was declared in an outbreak by PH.
The next day the ADOC confirmed that the home had not submitted a Critical Incident System (CIS) report to the Director.
The Inspector informed the ADOC of the requirement to immediately report an outbreak to the Director.
Seven days later the Inspector spoke with the CEO/DOC who confirmed that they were not aware of the requirement to inform the Director of the outbreak immediately and still had not notified the Director.

Sources: Interview with ADOC and CEO/DOC.

Issued on this 9th day of December, 2021

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

Original report signed by the inspector.