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
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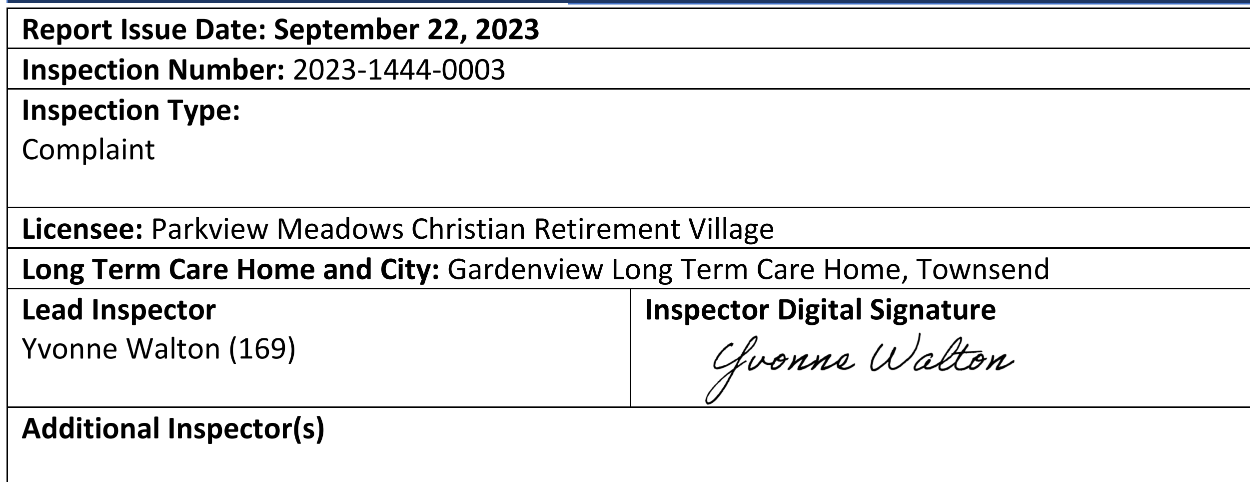
Original Public Report



Report Issue Date: September 22, 2023	
Inspection Number: 2023-1444-0003	
Inspection Type: Complaint	
Licensee: Parkview Meadows Christian Retirement Village	
Long Term Care Home and City: Gardenview Long Term Care Home, Townsend	
Lead Inspector Yvonne Walton (169)	**Inspector Digital Signature** Yvonne Walton
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 27, 28, 2023 and August 4, 16, 17, 18, 22, 25, 31, 2023
The inspection occurred offsite on the following date(s): August 1, 15, 23, 29, 2023

The following intake(s) were inspected:
- Intake: #00092343 and Intake: #00093028 related to plan of care, abuse and neglect, skin and wound care, weight loss, pain management and pest control.

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. i.

The licensee failed to ensure that resident #001 and his substitute decision maker were able to participate fully in the development, implementation, review and revision of their plan of care.

Rationale and Summary

Resident #001 had several changes in condition and their plan of care was revised. The Substitute Decision Maker (SDM) was not able to participate fully in the development, implementation, review and revisions to the resident's plan of care when these changes in condition occurred.
The following are examples as identified in the resident's clinical record, where the plan of care was revised and the SDM did not participate in the revisions.

- Resident #001 was admitted and within a short period of time the clinical record indicated the resident had a significant change in condition. The resident was monitored weekly and the plan of care revised without the involvement of the SDM on several occasions.

The SDM was denied the opportunity to fully participate in the development, implementation, review and revision of the plan of care when the resident's care needs changed throughout their stay.

Sources

This was confirmed by interviews with the physician, nursing staff ,substitute decision maker and documentation in the clinical progress notes.
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