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: January 23, 2024
Inspection Number: 2024-1444-0001
Inspection Type: Complaint Critical Incident
Licensee: Parkview Meadows Christian Retirement Village
Long Term Care Home and City: Gardenview Long Term Care Home, Townsend

Lead Inspector	**Inspector Digital Signature**
Klarizze Rozal (740765)	Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2024.01.24 09:18:05 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 5 and January 9-12, 2024.

The following intake(s) were inspected:

- Intake: #00100936- Critical Incident (CI) related to infection prevention and control.
- Intake: #00103284- Complaint related to physician medical services.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Agreement with Attending Physician

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 83 (b)
Agreement with attending physician
83. Where a written agreement between a licensee and a physician is required under subsection 82 (4), the agreement must provide for, at a minimum,
(b) the responsibilities of the licensee;

The licensee has failed to ensure a written agreement between the licensee and their physician under subsection 82 (4), provided the responsibilities of the licensee.

Rationale and Summary
The home's written agreement between the licensee and their Medical Director (MD) was approved on July 7, 2014. The Chief Executive Officer (CEO) acknowledged the licensee's responsibilities were not outlined in the written agreement.

Sources: MD written agreement on July 7, 2014, and interview with the CEO. [740765]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A) The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, revised in September 2023, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure that the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

On a specified date, multiple expired ABHR bottles were observed throughout the home. During observations, a staff member was observed in the home's entrance vestibule filling an expired ABHR wall dispenser bottle, with another ABHR bottle to fill its' contents. The staff member acknowledged they did not check the expiry dates on ABHRs in the home and would re-fill or add to the bottle contents when they noticed they were not full.

The IPAC lead acknowledged that ABHR should not be expired or mixed to ensure the product's full potential effectiveness and that expired ABHR does not meet the efficacy of the required 70-90% alcohol content.

Using expired ABHR may have decreased the efficacy and increased the risk of transmission of infections.

Sources: Observation of expired ABHR in the home and interviews with staff and the IPAC Lead. [740765]

B) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Specifically, a staff member failed to use proper personal protective equipment (PPE) in accordance with the "IPAC Standard for Long Term Homes, revised September 2023," by not ensuring that they were wearing the required PPE when they entered a resident room that was on additional precautions.

Rationale and Summary
As per 9.1 d) of the IPAC Standard, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, and at minimum routine practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

On a specified date, a staff member was observed to enter and provide care for a resident in an additional precaution room. The staff was observed not to don and wear the required PPE upon entering the room and providing care. The resident's PPE drawer did not have the required PPE available.

The staff member acknowledged they did not wear the required PPE when entering and providing care to the resident with additional precautions. They stated they were aware there was no specified PPE available in the PPE drawer prior providing care and it was their responsibility to ensure that supplies were available. The IPAC lead acknowledged that staff should be wearing the required PPE in resident rooms in additional precautions as per the home's IPAC procedures.

Failure to ensure that the staff was wearing the appropriate PPE when entering a resident room on additional precautions increased the risk for transmission of infection.

Sources: Observations, Droplet Transmission Precautions Policy, Respiratory Guidelines- Outbreak Detection and Management, and interviews with staff and the IPAC lead. [740765]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (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 (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director on a specified date for a specified outbreak that was declared 11 days earlier. The Director of Care (DOC) acknowledged that the outbreak CI was not submitted immediately when the outbreak was declared and no after hour reporting phone line submission was completed.

Sources: CI and interview with the DOC. [740765]

WRITTEN NOTIFICATION: Resident Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that residents' records were kept up to date at all times.

Rationale and Summary
During the course of inspection, multiple resident records were reviewed and found to be not up to date with the MD's assessments, findings, and treatments:

1. On a specified resident home area (RHA), the 2023 annual and admission physical examinations were reviewed. A registered staff explained that the MD documented their physical examination findings electronically on Point Click Care (PCC). On PCC review, multiple residents did not have written findings of their annual or admission physical examination in 2023. There were no hard copies of written examination findings in the residents' physical charts.
2. Weekly Physician Communication Records on a specified RHA and month were reviewed. Two residents had concerns and follow-up requirements recorded repetitively for four consecutive weeks. There were no records of an assessment or follow-up on both residents' clinical records by the MD during the four weeks.

On a specified date, the MD acknowledged they completed all 2023 annual and admission physical examinations on a specified RHA and assessed and treated both residents on a specified RHA. They explained they used an audio dictation program

to transcribe documentation into to their electronic tablet. They would then transfer the transcription into PCC. Inspector #740765 confirmed on the MD's electronic tablet, the completion of all the residents' physical examinations and their written findings and the follow-up for the two residents on a specified RHA. The MD acknowledged they have not transferred all their documentation and updated resident's records.

Failure to ensure that resident records were kept up to date, posed a risk to staff not being updated on resident assessment findings and treatments by the MD.

Sources: A specified RHA residents' clinical records, Weekly Physician Communication Records, review of records on MD's electronic tablet, and interview with a registered staff and the MD. [740765]