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: August 21, 2024
Inspection Number: 2024-1444-0002
Inspection Type: Critical Incident
Licensee: Parkview Meadows Christian Retirement Village
Long Term Care Home and City: Gardenview Long Term Care Home, Townsend

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 13, 14, 15, 16 and 19, 2024

The following intakes were inspected:

- Intake: #00110543 - Critical Incident (CI) related to prevention of abuse and neglect.
- Intake: #00118781 - CI related to infection prevention and control.
- Intake: #00122449 - CI related to falls prevention and management

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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: FLTCA, 2021, s. 25 (2) (d)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(d) shall contain an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to ensure their policy to promote zero tolerance of abuse and neglect of residents, contained an explanation of the duty under section 28 to make mandatory reports.

Review of the home's prevention of abuse policy did not include the explanation of the duty under section 28 to make mandatory reports to the Director immediately. Discussion with the Director of Care, they acknowledged the information was not included and updated the policy to include this information.

Date Remedy Implemented: August 19, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard, revised September 2023, issued by the Director was complied with.

Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) related to additional precautions was complied with for at a minimum point of care signage which indicated the enhanced IPAC control measures required.

Rationale and Summary
On an identified date in August, 2024, the door to a resident's room had personal protective equipment in place; however, there was no signage, which identified that contact precautions were required.
Once the concern was brought to registered practical nurse's (RPN's) attention they immediately put the signage back in place.

Sources: Observation of a resident's room and interview with RPN.

Date Remedy Implemented: August 13, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* are followed in the home.

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Chief Medical Officer of Health, specified that alcohol based hand rub (ABHR) must not be expired.

On an identified date in August,2024, several bottles of ABHR were observed in several areas of the home with expiry dates ranging from September 2021 to January 1, 2024. The Assistant Director of Cares (ADOC's) were informed and stated they would have the bottles removed and review their inventory. During a follow up observation, the expired bottles of ABHR were replaced with ones that had expiry dates in 2026.

Sources: Observations; recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Ministry of Health, April 2024); interview with the ADOC's and other staff.

Date Remedy Implemented: August 16, 2024

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an alleged incident of abuse to a resident by a staff member was immediately reported to the Director.

Rationale and Summary
On an identified date in March 2024, a resident reported pain to a specified area and that a staff member was rough with them. The home did not report the allegation of abuse to the Director until 4 days later and did not call the Ministry of Long-Term Care's Action Line.
An ADOC acknowledged the incident should have been reported immediately to the Director.

Sources: A Resident's clinical record; investigation notes; CI report and interview with ADOC.