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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Public Report

Report Issue Date: March 24, 2025

Inspection Number: 2025-1444-0002

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 date(s): March 13-14, 17-18, 20, 2025
The inspection occurred offsite on the following date(s): March 24, 2025

The following intake(s) were inspected:

- Intake: #00132670 - 2961-000011-24 - related to Infection Prevention and Control
- Intake: #00136436 -2961-000001-25 - related to Infection Prevention and Control

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that responsive behaviour strategies were implemented for a resident.

The resident had a responsive behaviour plan of care that identified strategies for the staff to use to respond to the responsive behaviours. Two Personal Support Workers (PSW) providing care to the resident did not follow the strategies identified in the resident's plan of care.

Sources: observations; interviews with two PSWs, and Director of Care; resident's clinical health record, including their care plan.

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).

The licensee failed to ensure that section 4.3 of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented.

Section 4.3 of the IPAC Standard for Long-Term Care Homes stated that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

A summary of findings with recommendations to the licensee for improvements to outbreak management practices was not available for three outbreaks over a five month period.

Sources: interview with Assistant Director of Care and Director of Care, review of IPAC Committee meeting minutes.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee failed to ensure that the home's written plan for responding to

infectious disease outbreaks was complied with.

In accordance with Ontario Regulation, 246/22, s.11. (1) b, the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with. Specifically, staff did not comply with the home's written plan for responding to infectious disease outbreaks.

The home's written plan for responding to infectious disease directed staff to notify public health when there were more than two residents with similar symptoms within 24 hours. The line listing identified multiple residents with similar symptoms within 24 hours. Staff did not notify Public Health of a potential outbreak until two days later, resulting in a delay in the outbreak being declared by Public Health.

Sources: interview with the Director of Care and Public Health; Disaster Plan - Outbreak.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee failed to ensure that the infection prevention and control (IPAC) lead

designated under this section worked regularly in that position on site at the home at least 17.5 hours per week.

Staff designated to fill the IPAC lead role also worked in another role within the home. The staff was unable to provide evidence to support that the minimum required hours were provided for the IPAC lead role.

Sources: interview with Assistant Director of Care and Director of Care.

WRITTEN NOTIFICATION: CMOH and MOH

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 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 were followed in the home.

Specifically, "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", effective October 2024 and February 2025, directed staff to complete weekly IPAC audits for the duration of an outbreak and for the results of these audits to be reviewed by the outbreak management team.

Not all weekly IPAC audits, including hand hygiene, Personal Protective Equipment

(PPE), and cleaning and disinfection audits, were completed as required during two identified outbreaks.

Sources: interview with Assistant Director of Care, Registered Nurse, Environmental Services Manager; IPAC hand hygiene and PPE audits for three months; IPAC Self Assessments for three months; environmental cleaning and disinfection audits for three months.