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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: July 15, 2025
Inspection Number: 2025-1444-0005
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: July 2-4, 7-10, and 14, 2025.

The following intakes were inspected:

- Intake #00149329 was related to falls prevention and management
- Intake #00151057 was related to infection prevention and control

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

Infection Prevention and Control
Falls Prevention and Management

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. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care related to falls risk interventions and had convenient and immediate access to it.

A resident had a fall and the post-fall assessment and interview with the nurse identified what may have contributed to that fall. This was documented in the progress notes. A personal support worker (PSW) that was interviewed during the inspection was not aware and had not received directions related to this falls risk intervention as they did not have access to the progress notes. On July 10, 2025, the home updated the resident's Kardex with this information, which the PSW's did have access to.

Sources: The resident's clinical records; and interviews with a PSW and RPN.

Date Remedy Implemented: July 10, 2025

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 (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 has failed to ensure that their written plan for responding to infectious disease outbreaks was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that any written plan developed for the infection prevention and control program was complied with. Specifically, the home did not comply with their plan for responding to infectious disease outbreaks when the definition of an outbreak was met.

The home's outbreak management plan stated that there was a suspect outbreak when two or more residents had been added to the monthly surveillance sheet with similar symptoms within a 48 hour time period and to then notify Public Health. The suspect outbreak definition was met for both units on June 23, 2025, however the Public Health unit was not notified and therefore an outbreak was not declared until June 25, 2025.

Sources: The home's monthly surveillance line listing and outbreak line listing, the home's outbreak management plan, and interviews with the IPAC Lead.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:
1) Provide education to the PSWs and nurses on identified home areas regarding the expected process for communicating any identified resident symptoms indicating the presence of infection between staff and how this is to be recorded. Home to keep a record of what education was reviewed and provided, date the education was reviewed and provided and name and signatures from the staff who received the education.

2) Provide education to the PSWs and nurses on identified home areas regarding the expectation that when a resident has symptoms indicating the presence of infection, they are to be monitored and recorded on every shift. Home to keep a record of what education was reviewed and provided, date the education was reviewed and provided and name and signatures from the staff who received the education.

3) Home to complete audit ensuring that any resident symptoms indicating the presence of infection as per the home's daily surveillance tracking, are being monitored and recorded on every shift. Audit to be completed for minimum one week period after at least one resident has presence of symptoms. Audit must

include name of resident(s), dates and shifts being audited and name and signature of person completing the audit.

Grounds

The licensee has failed to ensure that symptoms indicating the presence of infection in residents were recorded on every shift and that immediate action was taken to reduce transmission and isolate residents as required.

A) All symptoms indicating the presence of infection were not recorded on every shift for a resident when they began showing symptoms of a cough, runny nose, and sore throat. These symptoms were not recorded on until nine days later, when an order to monitor the residents cough was put in place and ordered to be done two times a day. The other symptoms were not addressed and the cough was not documented on every shift. Failing to record the symptoms of the residents infection may have delayed the home in identifying the presence of an outbreak earlier.

Sources: The resident's clinical records; the home's post outbreak debrief, outbreak line list and monthly surveillance list; and interviews with the IPAC Lead.

B) Immediate action to reduce transmission and isolate residents was not taken when three residents began showing signs and symptoms indicating the presence of infection. One resident was not isolated until 10 days after the onset of symptoms and two residents were not isolated until three days after the onset of symptoms. Not taking immediate action to isolate potentially infectious residents may have contributed to the spread of illness and the eventual respiratory outbreak that was declared on June 25, 2025.

Sources: The resident's clinical records; the home's post outbreak debrief, outbreak line list and monthly surveillance list; and interviews with the IPAC Lead.

This order must be complied with by August 25, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.