Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1451_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Mennonite Home Association of York County

Long-Term Care Home and City
Parkview Home Long-Term Care, Stouffville

Lead Inspector
Asal Fouladgar (751)

Inspector Digital Signature
Digitally signed by Asal Fouladgar
Date: 2022.09.26 11:21:38 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 23, 24, 25, 2022

The following intake(s) were inspected:

- Two intakes, including a complaint related to improper transferring of a resident resulting in death.

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

- Falls Prevention and Management
- Prevention of Abuse and Neglect

INSPECTION RESULTS

COMPLIANCE ORDER [CO#001] [PLAN OF CARE]

NC#001 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021 s. 6 (1) (c)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021 s. 6 (1) (c)

Specifically, the licensee must:

1. Implement and conduct a three-week audit to ensure that written care plans of all the residents in the home who require adaptive mobility devices (including but not limited to walker or wheelchair) are reflective of their actual mobility device use and care needs.

2. Implement and conduct a three-week audit to ensure written care plans of all residents who require any type of sling for the purpose of transferring, provide clear direction regarding the specific type of required transfer sling.

3. Ensure that the written care plan of any resident in the home who requires a specific adaptive equipment for the purpose of showering contain such information in the respective section of their written care plan including the required appropriate sling to be used as per the manufacturer's guide.

Grounds

Non-compliance with: FLTCA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) indicating the fall of a resident which resulted in an injury. The resident passed away few hours after the fall incident.

The resident's care plan indicated that they required a mechanical device with a specific assistive device for transfers. The type of assistive device was not noted in the resident's care plan. Further review of the resident's care plan indicated they had two different mobility devices for use related to their decline in mobility.

The home's Resource Nurse acknowledged that the resident's care plan did not have clear direction related to the type of assistive device to be used for their transfers. Personal Support

Worker (PSW) #112 stated that the type of assistive device must be indicated in residents' care plans.

The home's Physiotherapist (PT) acknowledged that the care plan was not providing clear direction to the staff related to the type of mobility device to be used for the resident.

Failure of the home to provide clear direction in the resident's written care plan related to the type of assistive device resulted in resident's fall and injury which led to their death. There was also risk of harm to the resident when their care plan did not provide clear direction to the staff related to the specific type of mobility device they required.

Sources: The resident's clinical records, CIS report, Interviews with PSW #112, the Resource Nurse, Physiotherapist, and other staff.

[751]

This order must be complied with by **October 14, 2022**

COMPLIANCE ORDER [CO# 002] [TRANSFERRING AND POSITIONING TECHNIQUES]

NC#002 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 246/22 s. 40

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 40.

Specifically, the licensee must:

1. Provide re-education to PSW #112 regarding:
   a) Safe transferring and positioning techniques
   b) A Specific transfer device use criteria as per the Manufacturer's guide

2. Document the education, including the date and the staff member who facilitated the education for section 1 of this order

3. Develop and implement a plan to train agency front line staff regarding the specific transfer device use criteria as per the Manufacturer's guide

Grounds

Non-compliance with: FLTCA, 2021 s. 40

The licensee has failed to ensure that the staff used safe transferring device when assisting a resident.

Rationale and Summary

A CIS report was submitted to the MLTC indicating the fall of a resident during a transfer which resulted in an injury. The resident passed away few hours after the fall incident.

The resident's written care plan included their transfer assessment dated prior to the fall incident, indicated a special type of assistive device with a specific size was required to transfer the resident using a mechanical device.

PSW #112 stated that with the assistance of another PSW, they used a different assistive device to transfer the resident during the shower. During the transfer, the resident slid from the assistive device and fell on the floor.

The Resource Nurse acknowledged that the staff did not use a safe transferring device when they used a wrong assistive device in order to transfer the resident.

Failure of the home to use a safe assistive device for the transfer, caused actual harm to the resident as they fell and sustained a significant injury which resulted in their death.

Sources: The resident's clinical records, CIS report, Interviews with PSW #112, the Resource Nurse, and other staff.

[751]

This order must be complied with by **October 14, 2022**

REVIEW/APPEAL INFORMATION

TAKE NOTICE

Ministry of Long-Term Care
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Long-Term Care Inspections Branch

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.