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

Central East District
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Original Public Report

Report Issue Date: May 23, 2024	
Inspection Number: 2024-1451-0003	
Inspection Type: Complaint	
Licensee: The Mennonite Home Association of York County	
Long Term Care Home and City: Parkview Home Long-Term Care, Stouffville	
Lead Inspector Deborah Nazareth (741745)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, May 1, 2, 6, 7, 8, 2024

The following intake was inspected in this complaint inspection:

- A complaint related to overmedication, falls and weight loss.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by a Registered Practical Nurse (RPN).

Ontario Regulation 246/22, s. 7 states that "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A complaint was received regarding the care of a resident by the Long-Term Care Home (LTCH). On a specified day, the day shift staff found injuries on the resident's body; no incident was reported. The resident was transferred to the hospital and required further intervention.

The LTCH's investigation discovered that the resident experienced an unwitnessed

incident during the previous night shift. The resident's incident was reported to the RPN by a Personal Support Worker (PSW). The RPN claimed they completed assessment of the resident during the night shift however, there was no documentation to support this. The RPN did not initiate and complete any post-incident assessments and they did not communicate to the oncoming shift that the resident had an incident.

The Director of Care (DOC) acknowledged that the RPN did not follow the LTCH's protocol for post-incident management and they did not initiate the required assessments for the resident. The RPN was aware of the expectations of the LTCH's policy and procedure, and they received discipline because of this incident.

The resident's well-being was jeopardized when the RPN neglected to assess the resident after an unwitnessed incident.

Sources: Resident's clinical record, LTCH investigation notes, LTCH policy "Fall Prevention Program", interview with the DOC. [741745]

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had an unwitnessed incident, they were assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A complaint was received regarding the care of a resident by the LTCH. On a specified day, the day shift staff found injuries on the resident's body; no incident was reported. The resident was transferred to the hospital and required further intervention.

The LTCH's investigation discovered that the resident experienced an unwitnessed incident during the previous night shift. The resident's incident was reported to the RPN by a Personal Support Worker (PSW). The RPN claimed they completed assessment of the resident during the night shift however, there was no documentation to support this. The RPN did not initiate and complete any post-incident assessments and they did not communicate to the oncoming shift that the resident had an incident.

The LTCH's policy for the Fall Prevention Program directs registered staff to complete post fall management which includes: a head-to-toe assessment, first aid as necessary, initiate an HIR for all unwitnessed falls and complete a post fall assessment.

The DOC acknowledged that the RPN did not follow the LTCH's protocol for post-incident management and they did not initiate the required assessments for the resident. The RPN was aware of the expectations of the LTCH's policy and

procedure, and they received discipline because of this incident.

Failure to complete the post fall assessment and head injury routine put the resident at risk as there could be delay in identifying any changes in status as a result of their unwitnessed incident.

Sources: Resident's clinical record, LTCH investigation notes, LTCH policy "Fall Prevention Program", interview with the DOC. [741745]

WRITTEN NOTIFICATION: Weight changes

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee has failed to ensure that when a resident had a greater than five per cent change in body weight over a one-month period, was assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated.

Rationale and Summary

A complaint was received related to weight changes for a resident. The resident experienced an 8.5 per cent (%) weight change over a one-month period. There was no dietary referral or assessment of the resident regarding their weight change until approximately a month later. However, this referral was sent related to new altered skin integrity that the resident developed.

The DOC confirmed the LTCH's policy on Weight and Height Monitoring directs registered staff to submit a dietitian referral for a weight change of 2.0 kgs or more or with weight changes of more than 5%. The DOC acknowledged that registered staff should have submitted a referral to the dietitian for the resident's weight change at the time the weight change was recorded.

When an interdisciplinary assessment was not initiated or completed in response to the resident's weight change, contributing factors were not identified, and actions were not taken to mitigate further deterioration or nutritional risk.

Sources: Resident's clinical record, LTCH policy "Weight & Height Monitoring", interviews with the DOC and others. [741745]