Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2013	2013_217137_0034	L-000707-13	Critical Incident System

Licensee/Titulaire de permis

PARKWOOD MENNONITE HOME INC.
726 New Hampshire Street, WATERLOO, ON, N2K-4M1

Long-Term Care Home/Foyer de soins de longue durée

PARKWOOD MENNONITE HOME
726 New Hampshire Street, WATERLOO, ON, N2K-4M1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 2, 2013

Reference Critical Incidents 2952-000015-13; 2952-000018-13; 2952-000019-13

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Attending Physician, one Registered Practical Nurse and two Personal Support Workers.

During the course of the inspection, the inspector(s) observed resident, toured resident's room, reviewed Falls Prevention Program, including staff education records related to falls prevention, relevant policies and procedures and resident's clinical records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of the incident of:
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital as evidenced by:

Three Critical Incidents, for two identified residents, were not submitted within the legislative requirements.

The Director of Care confirmed that the Director was not informed no later than one business day after the occurrence of the incidents and did not meet the legislative requirements. [s. 107. (3)]

Issued on this 3rd day of October, 2013

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs