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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2016	2016_216144_0077	029706-16	Resident Quality Inspection

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

CAROLEE MILLINER (144), ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 12, 13, 14, 17, 18, 2016.

During the course of the inspection, the inspector(s) spoke with twenty plus residents, four family members, one Family Council representative, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Registered Dietician (RD), Program Manager, two Registered Nurses (RN's), seven Registered Practical Nurses (RPN's), nine Personal Support Workers (PSW's), two Housekeeping Aides (HA) and one Food Service Worker (FSW).

During the course of the inspection, the inspector(s) toured all resident home areas, medication rooms, medication administration, provision of care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be clothed in a manner consistent with his or her needs.

One identified resident was observed in the lounge on one identified home area.

Two PSW's told the Inspector that the resident was scheduled for a bath at 0730 hours which was cancelled and that the resident was not dressed as they (PSW's) believed the bath would be completed before the lunch meal.

The DOC confirmed with the Inspector that it was inappropriate for the resident to be dressed in this manner in an open lounge at any time and that when the resident's bath was cancelled, the resident should have been dressed in appropriate day clothing. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident had the right to be clothed in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On one a housekeeping cart was observed on Weber Woods resident home area outside the meeting room door. The cart was locked and unattended with the key to the locked compartment wrapped around a bottle of hand sanitizer on top of the cart. The Inspector used the key to access the locked compartment of the housekeeping cart and observed six different bottles of chemicals inside.

PSW's #109 and PSW #110 told the Inspector that the key to the cart was normally kept with housekeeping staff when the cart was not in use.

At 1034 hours, Housekeeping Aide #111 shared with the Inspector that the housekeeping cart was usually placed in the janitor's closet when not in use and that the key was kept with the Housekeeping Aide. Housekeeping Aide #111 shared that they did not store the housekeeping cart in the janitor's closet when they left the area to deliver laundry as they believed they would not be away from the cart for long and that they forgot to take the key with them.

DOC #100 confirmed it is her expectation that housekeeping personnel keep the key to the housekeeping cart with them during their shift so that chemicals in the cart would not be accessed by residents. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On October 12, 2016 at 1120 hours, during observations on Weber Woods resident home area, a medication cart was noted to be unlocked and unattended in the hallway by the lounge and the den where fifteen residents were present. One visitor and one volunteer were standing near the cart and left the area. The Inspector observed the medication cart for five minutes before a registered staff member returned to the cart.

RN #101 confirmed the Inspector's observation and told the Inspector that the home's expectation was that medication carts would be locked when unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

Issued on this 17th day of November, 2016

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

Original report signed by the inspector.