Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Lynne Haves
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	025945-17
Original Inspection #:	2019_787640_0004
Licensee:	Parkwood Mennonite Home Inc. 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
LTC Home:	Parkwood Mennonite Home 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
Name of Administrator:	Elisabeth Piccinin

Background:

Ministry of Health and Long-Term Care (MOHLTC) conducted an inspection at Parkwood Mennonite Home (LTC home) on January 21, 22, 23, 24 and 28, 2019. The inspection was a complaint inspection.
During the inspection, the Inspector found that the Licensee, Parkwood Mennonite Home Inc., (the Licensee) failed to comply with s. 6 (7) and s. 33 (4) of the Long-Term Care and Homes Act, 2007 (LTCHA) and issued Compliance Order #001 and Compliance Order #002.
Compliance Order #001
"The licensee must be compliant with s. 6 (7) of the LTCHA 2007.

Specifically, the licensee must ensure that the care set out in the plan of care for residents #001, #002, #005 and #006 and any other resident is provided as specified in the plan.

Order #:	001

To **Parkwood Mennonite Home Inc.**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order:

Director's Order #001 is being made pursuant to section 153(1)(a) of the LTCHA.

The Licensee must be compliant with s. 6 (7) and s. 6 (9) of the LTCHA.

s. 6 (7) of the LTCHA

1. The Licensee shall ensure that the care set out in the plan of care for Residents #001, #002, #005 and #006; and any other resident, including, but not limited to, all residents identified is provided to that resident as specified in the plan.

s. 6 (9) of the LTCHA

1. The Licensee shall ensure that the following are documented for Residents #001, #002, #005 and #006; and any other resident:
a) The provision of the care set out in the plan of care;
b) The outcomes of the care set out in the plan of care; and
c) The effectiveness of the plan of care.
2. The Licensee shall ensure that staff properly document all plan of care reports.
3. The Licensee will monitor and audit plan of care reports monthly to ensure that staff on all shifts are documenting the provisions and outcomes as set out in the plan of care.
4. The Licensee will provide support and education for proper charting of clinical reports.

Grounds:

The Licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan and documented accordingly.

Resident #001

• Resident #001 had sustained multiple falls since their admission to the Long-Term Care Home.
• The plan of care was reviewed and stated that two safety devices were to be worn by the resident.
• On an identified date, Resident #001 fell, and the clinical record showed that the resident was not wearing the safety devices.
• The progress notes for the falls that occurred on specific dates all stated that Resident #001 was wearing the safety devices at the time of the incident.
• The progress notes for an identified date stated that Resident #001 was wearing the safety devices.
• During an interview with Inspector #640, PSW #102 confirmed that Resident #001 must always wear the safety devices.
• Inspector #640 reviewed the clinical records for specified months and identified 30 shifts where the safety devices were not documented into the Point of Care system by staff as being worn by Resident #001.

Resident #002
• Resident #002 sustained unwitnessed falls on identified dates.
• On an identified date, the resident sustained an injury.
• As noted in the plan of care, safety devices were to be worn at all times.
• The clinical records related to a fall on an identified date showed that Resident #002 was wearing one safety device at the time and not the other.
• Inspector #640 reviewed clinical records for several identified months. The inspector identified 19 undocumented shifts in the Point of Care system failing to indicate that the safety devices were worn by Resident #002.
• In interviews with Inspector #640, PSW #110 and PSW#111 confirmed that Resident #002 must always wear the safety devices and must document each application into the Point of Care system.

Resident #005
• Resident #005 sustained falls on identified dates.
• There is no documentation to show that the safety devices were worn. The falls were all pre-implementation date.
• As in the plan of care, safety device was to be worn by the resident.
• Inspector #640 reviewed the clinical records for one month and identified 16

undocumented shifts in the Point of Care system failing to indicate that the safety device was worn by Resident #005.
• In an interview with Inspector #640, PSW #108 confirmed that Resident #005 must always wear the safety device. The PSW also advised that the staff are required to document each application of the clip alarm into the Point of Care system.

Resident #006
• Resident #006 sustained an unwitnessed fall on an identified date.
• As noted in the plan of care Resident #006 was to wear the safety device on days, evenings, and nights."
• The clinical records do not indicate that the resident was wearing the safety device at the time of the fall.
• Inspector #640 reviewed clinical records for several months and identified 9 shifts where there was no documentation that the safety device was worn by Resident #006.
• In interviews with Inspector #640, PSW #110 and PSW#111 both confirmed that Resident #006 must always have the safety device in place and they also advised that they are required to document each application of the safety device.
The Licensee failed to ensure that the care set out in the plan of care is provided to the residents as specified in the plan and properly documented.

This order must be complied with by:	May 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

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

Issued on this 8th day of April, 2019	
Signature of Director:	
Name of Director:	Lynne Haves