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 #002

In reviewing the legislative reference of this Order, the Inspector was incorrect in listing s. 33 (4) of O. Reg. 79/10. This specific section is listed under s. 33 (4) of the LTCHA 2007 and not the Regulation.

"The licensee must be compliant with s. 33 (4) of O. Reg. 79/10.

Specifically, the licensee must ensure that:

a) The use of a personal assistance services device (PASD) for residents #001 and #005 and any other residents are approved by a regulated healthcare professional, and
b) Prior to the implementation of a PASD for residents #001, #002 and #005, and any other residents, the PASDs are consented to by the resident or the resident's SDM.

Order #:	002

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. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order:

Director's Order #002 is being made pursuant to section 153(1)(a) of the LTCHA.

The Licensee must be compliant with s. 33 (4) of the LTCHA.

Specifically the Licensee must ensure that:

a) The use of a personal assistance services device (PASD) for Residents #005 and any other residents, are approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.
b) Prior to the implementation of a PASD for Resident #001, Resident #002 and Resident #005 and any other residents, the use of the PASD must be consented by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Grounds:

1. The Licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) had been approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations prior to it's implementation.

Resident #001
• Resident #001 sustained unwitnessed falls on identified dates.
• On an identified date, Resident #001 was transferred to the hospital and returned to the LTC home the same day with a medical diagnosis.
• The plan of care states that Resident #001 had a Personal Assistance Services Devise (PASD).
• On a specified date, the Restorative Care Lead documented that they observed the resident to be using a PASD.
• On an identified date, Resident #001 was assessed by the Occupational Therapist (OT) for a PASD which was already in use. On the same date, the PASD was included in the resident's plan of care. The approval was granted one day after the PASD was already in use.
• Inspector #640 reviewed the clinical records, and there is no evidence that consent was provided by Resident #001 or their SDM to support the use of the PASD.
• In an interview with Inspector #640, the Restorative Care Lead acknowledged the PASD for Resident #001 had been implemented without the prior approval

of a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.
• In interviews with Inspector #640, PSW #102 and PSW #108 advised that Resident #001 could not get out from the PASD and the PASD was used for safety and comfort.
• RPN #100 informed Inspector #640 that when a PASD is believed to be of benefit to a resident, they are to advise the Restorative Care Lead who then informs the OT. The OT will then assess the resident for the appropriateness of the PASD.

Resident #002
• Resident #002 sustained unwitnessed falls on identified dates.
• Resident #002 was assigned a PASD following a fall.
• A notation in the plan of care states that Resident #002 is to use the PASD
• Inspector #640 reviewed the clinical records, and there was no evidence of a consent provided by the substitute decision-maker to support the use of the PASD.
• In interviews with Inspector #640, PSW #110 and PSW #111 stated that Resident #001 could not get out from the PASD and it was used for safety and comfort.

Resident #005
• Resident #005 sustained falls on identified dates.
• An entry in the plan of care states that Resident #005 was to be checked hourly for safety when the PASD was applied. No notation of an assessment by a regulated healthcare professional was in the plan of care.
• Inspector #640 reviewed the clinical records and there is no evidence to support that the use of the PASD was approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.
• Inspector #640 reviewed the clinical records and there was no evidence of a consent provided by the substitute decision-maker to support the use of the PASD for Resident #005.
• RPN #100 informed Inspector #640 that when a PASD is believed to be of benefit to a resident, they are to advise the Restorative Care Lead who then informs the OT. The OT will then assess the resident for the appropriateness of the PASD.
• In interviews with Inspector #640, PSW #110 and PSW #111 both stated that Resident #001 could not get out from the PASD and the PASD was used for safety and comfort.
• In an interview with Inspector #630, the Restorative Care Lead acknowledged the PASD for Resident #001 had been implemented without the approval of a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

2. Prior to the implementation of a PASD for Resident #001, Resident #002 and Resident #005 and any other residents, the Licensee failed to obtain consent for the use of the PASD by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #001
• The plan of care states that Resident #001 uses the PASD all of the time.
• On an identified date, the Restorative Care Lead documented that they observed the resident to be using the PASD.
• Inspector #640 reviewed the clinical records, and there is no evidence that consent was provided by Resident #001 or their SDM to support the use of the PASD.
• In interviews with Inspector #640, PSW #102 and PSW #108 advised that Resident #001 could not get out from the PASD and it was used for safety and

comfort.

Resident #002
• A notation in the plan of care states that Resident #002 is to use the PASD.
• Inspector #640 reviewed the clinical records, and there was no evidence of a consent provided by the substitute decision-maker to support the use of the PASD.
• In interviews with Inspector #640, PSW #110 and PSW #111 stated that Resident #001 could not get out from the PASD and it was used for safety and comfort.

Resident #005
• An entry in the plan of care states that Resident #005 to be checked hourly for safety when in PASD.
• Inspector #640 reviewed the clinical records and there was no evidence of a consent provided by the substitute decision-maker to support the use of the PASD for Resident #005.
• In interviews with Inspector #640, PSW #110 and PSW #111 both stated that Resident #001 could not get out from the PASD and it was used for safety and comfort.

The severity of harm was classified as a level 2, the potential for actual harm to residents. The scope of the issue was a level 3 and identified as widespread; as there were 3 out 3 residents identified from the affected surveyed population. The history was classified as a 2, the Licensee has a history of one or more unrelated non-compliance issued in the last 36 months. Non-compliance with the legislative or regulatory provisions are considered even if the circumstances, details or individuals are different.

This order must be complied with by:	April 30, 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