Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2020	2020_508137_0004	023841-19	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): January 30, 2020

The following intake was completed in this Critical Incident System (CIS) inspection related to falls prevention:
2952-000010-19 and Log #023841-19.
A Complaint Inspection, related to 24/7 Registered Nursing coverage, was also conducted concurrently during this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Chief Executive Officer, Restorative Care Coordinator and Administrative Assistant.

The Inspector also reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for an identified resident that:
(a) set out the planned care for the resident,
(b) the goals the care was intended to achieve and
(c) clear directions to staff and others who provided care to the resident.

A Critical Incident System (CIS) report, was submitted to the Ministry of Long-Term Care (MLTC) where the identified resident sustained a fall with injury, which resulted in a significant change in the resident's health status.

A record review showed that, during a specified time period, the identified resident was assessed twice as a moderate risk for falls and then as a high risk during four subsequent assessments.

There was no documented evidence that falls and fall prevention interventions, to mitigate falls, were identified on the care plan, until the resident sustained a fall with injury, on a specified date.

During an interview, Director of Care #104 and Assistant Director of Care #102 said falls had not been identified on the care plan until the resident sustained a fall with injury and

the expectation was that falls should have been identified and interventions in place to mitigate falls, so that clear directions were provided to staff who provided care to the identified resident. [s. 6. (1)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when an identified resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) where the identified resident sustained a fall with injury, which resulted in a significant change in the resident's health status.

A record review showed that, during a specified time period, there were multiple documented entries in Point Click Care (PCC) where the resident expressed pain. A pain assessment was completed and the resident described the pain as terrible and interfered with their sleep. Documentation showed that pain management interventions were ineffective and required the attending physician to increase analgesic medication.

There was no documented evidence that pain and pain management interventions were identified on the care plan.

During an interview, Director of Care #104 and Assistant Director of Care #102 said pain had not been identified on the care plan and the expectation was that the plan of care should have been reviewed and revised to identify pain and pain management interventions for the identified resident. [s. 6. (10) (b)]

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 there is a written plan of care for residents that:
(a) sets out the planned care for the residents,
(b) the goals the care is intended to achieve and
(c) clear directions to staff and others who provide care to the resident and to ensure that the plan of care is reviewed and revised when a resident's care needs change, to be implemented voluntarily.

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.