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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2020	2020_821640_0012	001802-20, 003781-20	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

HEATHER PRESTON (640)

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): July 6, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21 and 22, 2020.

During the course of the inspection, the Long Term Care Homes (LTCH) Inspector toured the home, conducted interviews, reviewed clinical records and policy/procedure, observed the provision of care and talked with residents and/or family members.

The following Critical Incident (CI) reports were reviewed:

Log #001802-20 related to a fall with injury and responsive behaviours.
Log #003781-20 related to injury of resident during care.

NOTE: THIS INSPECTION WAS CONDUCTED CONCURRENTLY WITH COMPLAINT INSPECTION #2020_821640_0013.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision makers (SDM), personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), agency staff, Behaviour Supports Ontario (BSO) staff, Clinical Coordinators, Assistant Directors of Care, Directors of Care and the Executive Director.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The licensee submitted a Critical Incident (CI) Report regarding resident #003 who sustained an injury during care.

PSW #101 said that during the provision of a bed bath on a specified date in March 2020, the resident was resistive to care.

PSW #101 said that an intervention for this resident, if being “too” resistive, as included in their plan of care, was to stop and re-approach later.

PSWs #101 and #104 said they did not stop the action, leave and re-approach.

The plan of care in place at the time of the incident directed staff that when the resident was resistive to care, to give them five to ten minutes and then come back.

The licensee failed to ensure that the care set out in the plan of care, was provided as specified to resident #003. [s. 6. (7)]

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 the licensee must ensure that the care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #003, #004 and #005 were provided their bathing method of choice.

a) The licensee submitted a Critical Incident (CI) Report regarding resident #003 who sustained an injury during care on a specified date in March 2020.

At the time of the incident, the resident was being provided a bed bath. PSW #101 said that they did not know the bathing preference.

PSW #104 said the resident's preferred bathing type was a shower and believed that a bed bath was included in the plan of care.

The plan of care in place at the time of the incident, directed staff that the resident preferred a shower.

The bath and shower schedule kept on the home area had resident #003 scheduled for a shower on two days per week.

Care Conference Assessment, which was attended by the resident's substitute decision makers, identified that a shower was the preferred method of bathing.

RN #100 said it was expected that staff implement the plan of care as written.

b) PSW #108 said that resident #004's preferred bathing type was a shower. Their preference of a shower was identified at the time of admission and had not changed. They said that the resident didn't always get a shower but was unsure why.

The plan of care directed staff that the resident preferred a shower.

The bath and shower schedule kept on the home area, directed that resident #004 was scheduled for a shower two days per week.

c) PSW #108 said the resident #005's preferred bathing type was a shower. Their preference of a shower was identified at the time of admission and had not changed. They said that the resident didn't always get a shower but was unsure why.

The plan of care directed staff that they preferred a shower.

The bath and shower schedule kept on the home area, directed that resident #005 was scheduled for a shower on two evenings per week.

The licensee failed to ensure that resident #003, #004 and #005 were provided their preferred bathing choice. [s. 33. (1)]

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 the licensee must ensure that residents are provided their bathing method of choice, to be implemented voluntarily.

Issued on this 25th day of August, 2020

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

Original report signed by the inspector.