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
Sep 24, 2021	2021_796754_0025	010596-21	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

TAWNIE URBANSKI (754)

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): September 20-22, 2021.

The following intake was completed during this Critical Incident Inspection:
Log #010596-21, related to an incident where a resident required transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Worker (PSW), Dietary Aide, and a Housekeeper.

The inspector also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, internal investigation notes and training records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration

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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was provided with safe fluids.

A resident had an episode during a mealtime, requiring them to be transferred to hospital. They were later assessed by the Dietitian, and their dietary plan of care was revised to ensure the resident received safe food and fluids based on their individual needs.

Inspector #754 observed the resident during a lunch meal. The resident was observed to be drinking fluids that were not deemed safe for them as per their plan of care.

RPN #102 said the resident should not have consumed those fluids, and they should have received fluids as per their plan of care.

By not ensuring the resident was provided safe fluids as per their plan of care with their lunch meal, the resident was at increased risk for choking.

Sources: CIS #2952-000008-21, resident #001's care plan, progress notes, Dietitian assessments, Observations, and Interview with RPN #102. [s. 11. (2)]

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 residents are provided with food and fluids, that are safe, to be implemented voluntarily.

Issued on this 6th day of October, 2021

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

Original report signed by the inspector.