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
Mar 17, 2022	2022_792659_0004	003643-22	Proactive Compliance Inspection

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

JANETM EVANS (659), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): March 1, 2, 3, 4, 7, 8, 9, 10 and 11, 2022

The following intake was included in this inspection : Log # 003643-22 Proactive Compliance Inspection (PCI)

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Chief Executive Officer, Director of Operations, Director of Clinical Services (DCS), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Service Workers (ESWs), students, Resident Council lead, Family Council lead, residents and family members.

Observations were completed for Infection Prevention and Control (IPAC) procedures, medication administration and storage areas, resident dining and snack service, staff to resident interactions, general resident care and cleanliness and window openings. A review of relevant documents was completed which included but was not limited to: plans of care, progress notes, medication incidents, Professional Advisory Committee (PAC) meeting minutes, Resident and Family Council meeting minutes, programs, program evaluations and policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

The ED stated that the annual resident satisfaction evaluation of continence care products were not completed for the year 2021, in consultation with residents and SDMs and direct care staff.

Not completing the annual resident satisfaction evaluation of continence care products in 2021 meant that residents, SDMs and direct care staff did not have the opportunity to evaluate the effectiveness and the level of their satisfaction with the continence care products.

Sources: PMH Residents - Prevail by 1st Quality Product Evaluation Survey" competed for the year 2020, interview with ED [s. 51. (1) 5.]

2. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage their bladder continence based on the assessment and that the plan was implemented.

On two specified dates in 2021, a verbal complaint was made to a registered staff indicating a resident was incontinent.

On a specified date in 2022, a written complaint was made to three managers, related to the resident's incontinence episodes and a more absorbent product was requested.

On two specified days in 2022, verbal complaints were made to registered staff that the resident needed to be changed. A more absorbent product was requested.

Staff were aware of the complaint but the resident was not assessed for, or provided a more absorbent product.

Not assessing the resident for a more absorbent product and implementing this as part of their plan of care did not promote dignity and comfort for the resident.

Sources : Observations, Written complaints, review of plan of care and progress notes, interview with the SDM, ED, ADOC and staff. [s. 51. (2) (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 that residents who are incontinent have an individualized plan of care to promote and manage continence based on an assessment and that the plan is documented and implemented. As well the home is to ensure that an annual evaluation of residents' satisfaction with the range of continence care products is completed in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being documented and taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of Surge learning for 2021 showed that 75.5% of direct care staff or 47 of 62 staff had completed the training to promote zero tolerance of abuse and neglect of residents.

The Director of Clinical Services (DCS) acknowledged that the training had not been completed all staff.

When all staff are not provided annual training on the home's policy to promote zero tolerance of abuse and neglect of residents, there was risk that concerns related to possible abuse or neglect would not be recognized, staff may not be aware of the homes processes, or concerns may not be reported in a timely manner to the Director.

Sources: Surge learning 2021, interview with the DCS [s. 76. (4)]

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 all staff receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

A written complaint was made to the three managers by a Substitute Decision Maker (SDM) concerning a resident's care.

The ED stated that the home did not investigate, resolve, or provide a response to the SDM within 10 business days of receipt of the complaint.

Sources : Written complaint, policy on Complaint Process and interview with the ED. [s. 101. (1) 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 to ensure that every written or verbal complaint made to the licensee or a staff member, concerning the care of a resident or operation of the home is investigated, resolved where possible and a response provided withing 10 business days of receipt of the complaint, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

No documented interdisciplinary quarterly review of all medication incidents and adverse drug reactions that had occurred in the home since the last review July 2021 was provided for review.

The DCS acknowledged a quarterly review of all medication incidents and adverse drug reactions had not been completed since the last PAC - July 2021.

Not completing a quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review is a missed opportunity for timely correction of errors to prevent harm or risk of harm to residents.

Sources: June 2021 Medication Incident and Near Miss Summary Report, Minutes PAC summary July 21, 2021, interview with the DCS. [s. 135. (3)]

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 a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in falls prevention and management, skin and wound care and pain management, including recognition of specific and non-specific signs of pain.

The home's policy for falls prevention and management said that all direct care staff

would receive training during orientation and that all direct care staff would receive annual training on falls prevention and management including safe and correct use of equipment which covered mechanical lifts, assistive aids and positioning aids.

Review of Surge learning for 2021 showed 67.7% of direct care staff or 42 of 62 staff had completed the training on skin and wound care.

When all direct care staff were not provided annual falls prevention training, residents' who were at risk for falls may not be assessed and have appropriate fall prevention measures implemented in a timely manner, putting them at risk for falls and possible injuries.

Sources: Fall Prevention and Management Program, ref #NM005190, revised Sept 16, 2021; Surge learning 2021, interview with the DCS [s. 221. (1) 1.]

2. Review of Surge learning for 2021 showed 67.7 % of direct care staff or 42 of 62 staff had completed the training on skin and wound care.

When all direct care staff were not provided annual skin and wound management training, there was risk that residents' skin and wound concerns wound not be identified or managed in a timely manner.

Sources: Skin and Wound Management Program NM006010.00 revised September 23, 2021; Surge learning 2021, interview with the DCS. [s. 221. (1) 2.]

3. The home's pain management program documented that prior to assuming their job responsibilities, direct care staff must receive training on pain management including pain recognition of specific and non-specific signs of pain. Direct care staff must receive annual retraining on pain management including pain recognition of specific and non-specific signs of pain. .

Surge learning: documented 56 of 62 staff or 90.3% completed the training on pain management, including recognition of specific and non-specific signs of pain. for 2021.

When direct care staff were not provided annual pain management training, there was risk that a resident's pain would go unnoticed or treated.

The Director of Clinical Services (DCS), acknowledged that not all staff had completed

the required training in falls prevention, skin and wound care and pain management, including recognition of specific and non-specific signs of pain.

Sources:Pain Assessment and Management Program, ref # NM005300.00 revised July 15, 2022; Surge learning 2021, interview with the DCS. [s. 221. (1) 4.]

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 all direct care staff are provided with annual training in falls prevention and management, skin and wound care and pain management, including recognition of specific and non-specific signs of pain., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a hand-hygiene program in accordance with evidence-based practices.

The home's hand hygiene program dated February 2022, documented indications for staff hand hygiene. The program said that annual education would be provided for residents, families and visitors related to hand hygiene but it did not include that staff would encourage or assist residents to complete hand-hygiene.

Three observations of dining and snack time on two different units showed staff who did not remind, encourage, or assist the residents in performing hand hygiene.

The Director of Clinical Services (DCS) acknowledged their program of hand hygiene did not include that staff would remind, encourage, or assist the residents in performing hand hygiene.

On March 10, 2022, the DCS provided a resident hand hygiene program document, dated March 8, 2022. The document stated residents would be provided assistance if needed to complete hand hygiene.

Not ensuring the home's hand hygiene program was based on best practice to encourage or assist residents with hand hygiene may mean staff are not aware they should assist residents with hand hygiene prior to and following snacks and increase the potential risk of pathogen spread.

Sources: observations, Hand Hygiene Program, IC005050.00, revised February 2022, Resident Hand hygiene, dated March 8, 2022, and interviews with with staff and the DCS. [s. 229. (9)]

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 the home's hand hygiene program includes that staff should encourage and assist residents with hand hygiene prior to and following meals and snacks, toileting, or when hands are soiled, in accordance with best practice. All staff should receive training on the updated hand hygiene program for residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home was forwarded to the Director immediately.

A complaint was submitted to three managers in January 2022, concerning a resident's care.

The ED stated that the written complaint was not forwarded to the Director.

Not forwarding written complaints that had been received concerning the care of resident #007, meant the Director was not given an opportunity to respond or intervene if necessary.

Sources: written complaint and interview with the ED. [s. 22. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

There was no documentation to show that an interdisciplinary team, which included the persons as listed above, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The DCS acknowledged that the interdisciplinary team had not met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The risk of not meeting at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system may be a missed opportunity to address medication incident concerns and be proactive in implementing measures to prevent further incidents.

Sources: Record review PAC minutes dated July 21, 2021, interview with the DCS. [s. 115. (1)]

Issued on this 23rd day of March, 2022

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

Original report signed by the inspector.