Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: January 25, 2023

Inspection Number: 2023-1435-0001

Inspection Type:
Critical Incident System

Licensee: Parkwood Mennonite Home Inc.

Long Term Care Home and City: Parkwood Mennonite Home, Waterloo

Lead Inspector	**Inspector Digital Signature**
Gabriella Del Principe (741734)	Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.01.26 09:32:07 -05'00'

Additional Inspector(s)
Olive Nenzeko (C205)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 16-20, 2023

The following intakes were completed in this Critical Incident System (CIS) inspection:

- Intake #00001910 and Intake #00005536 were related to falls prevention and management
- Intake #00017666 was related to alleged abuse

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the Director was immediately informed of an incident of suspected staff to resident abuse.

Rationale and Summary:

On a day in January 2023, a staff member suspected that another staff member had abused a resident. The staff member that witnessed the suspected abuse reported their concerns to their supervisor the following day, and the incident was not reported to the Director until two business days later.

By not reporting the incident of suspected abuse to the Director immediately, the Director was unable to respond immediately.

Sources: Critical Incident Report, review of the home's investigation notes, and interviews with staff members.

[740884]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident's rights were fully respected and promoted when they were not treated with courtesy and respect by a staff member.

Rationale and Summary:

On a day in January 2023, one staff member witnessed another staff member grab a resident by their arm, attempting to have the resident sit down. When the resident resisted, the staff member acted inappropriately, causing the resident to yell and spill their beverage onto the floor.

Failing to ensure that the resident's rights were fully respected and promoted and that they were treated with courtesy and respect could have had a negative impact on the resident.

Sources: Interviews with staff members, Critical Incident Report, and the home's investigation notes including written statements from staff members.

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