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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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: April 3, 2024	
Inspection Number: 2024-1435-0002	
Inspection Type: Complaint	
Licensee: Parkwood Mennonite Home Inc.	
Long Term Care Home and City: Parkwood Mennonite Home, Waterloo	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2024.04.04 08:46:03 -04'00'
Additional Inspector(s) N/A	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11 - 15, 2024

The following intake(s) were inspected:

- Intake: #00108905 - related to concerns with continence care, skin and wound care, and transfers

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident related to two programs, including interventions and the resident's responses to interventions were documented.

Rationale and Summary

On multiple occasions, staff had documented that they provided specific interventions to a resident as per their plan of care.

Video surveillance footage showed that care was not provided as per the resident's plan of care.

The Director of Care (DOC) stated that staff documentation should accurately reflect the care that was provided to the resident.

Sources: Video surveillance footage, resident's care plan, Documentation Survey Report v2, point of care task documentation, interviews with complainant, DOC and other staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices and techniques when assisting a resident.

Rationale and Summary

A resident required specific assistance with their transfers and repositioning using specific devices and techniques.

On multiple occasions, staff did not provide a resident with the assistance they required or use the required devices and techniques to assist the resident.

When safe transferring and positioning devices and techniques were not used by staff, the resident was at risk of becoming injured.

Sources: Video surveillance footage, resident care plan, kardex, point of care task documentation, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (d)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

The licensee failed to ensure that a resident received the assistance and support from staff to be continent.

Rationale and Summary

Staff were required to provide a resident assistance and support to be continent.

On multiple occasions, the resident did not receive assistance and support from staff to be continent, resulting in several episodes of incontinence. On some of these occasions, the resident used the call bell for assistance to be to continent, and staff did not respond for approximately one hour. As a result, the resident attempted to self-transfer out of bed, and became incontinent before staff responded to assist them.

When the resident did not receive assistance and support from staff to be continent, they had episodes of incontinence and attempted to self-transfer which put them at risk of falling.

Sources: Video surveillance footage, a resident's care plan, progress notes, Documentation Survey Report v2, interviews with complainant, DOC and other staff.