

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 30, 31, Nov 1, 19, 20, 22, 2012	2012_069170_0029	Complaint
Licensee/Titulaire de permis		
PARKWOOD MENNONITE HOME INC 726 New Hampshire Street, WATERLO Long-Term Care Home/Foyer de soin	O, ON, N2K-4M1	
PARKWOOD MENNONITE HOME 726 New Hampshire Street, WATERLO	O, ON, N2K-4M1	
Name of Inspector(s)/Nom de l'inspec	cteur ou des inspecteurs	
DIANNE WILBEE (170)		
Ins	pection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Program Aide and Residents.

During the course of the inspection, the inspector(s) observed residents on home area, observed resident off home area and reviewed residents' health care records, reviewed log tracking, reviewed 24 hour Resident Condition Report.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

	<u>a programs, menggapan menggamakan keranggapan ang kapada pada ang ang kapada menggapan keranggapan kanang</u>
NON-COMPLIANCE / NON	I-RESPECT DES EXIGENCES
Legend	Legendé
	WN – Avis écrit
	VPC = Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
	CO - Ordre de conformité
WAO – Work and Activity Order	WAO - Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the 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 LTCHA includes the requirements contained in the items listed in 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 subsections:

- s. 6. (9) The licensee shall ensure that the following are documented:
- 1. The provision of the care set out in the plan of care.
- 2. The outcomes of the care set out in the plan of care.
- 3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).
- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
- (a) a goal in the plan is met;
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants:

- 1. The licensee did not ensure that the provision of care set out in the plan of care for an identified resident was consistently documented on monitoring logs as follows:
- (a) The resident expressed concerns which resulted in the home commencing a monitoring log. The log was for two consecutive weeks and monitoring of the resident was to be completed at half-hour intervals. The provision of this care was not documented on the log for 173 half-hour entries over the two week interval. [Reference: LTCHA, 2007, S.O. 2007, c.8, s.6(9)1]
- 2. The licensee did not ensure an identified resident's plan of care was reviewed and revised to reflect changes in the resident's condition related to expressed concerns, by the resident, and the impact of environmental circumstances on the resident and corresponding interventions to support the resident. [Reference: LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]

Issued on this 22nd day of November, 2012



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

Diane Kelber #170