Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 12, 30, 2014	2014_271532_0015	L-000537-14	Resident Quality 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

NUZHAT UDDIN (532), DEBORA SAVILLE (192), DOROTHY GINTHER (568), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 06, 07, 08, 09, 12, 13, 14 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Coordinator, Assistant Director of Care, Restorative Coordinator, Environmental Service Manager, Registered Dietitian, Program Director, 2 Registered Nurses, 8 Registered Practical Nurses, 12 Personal Support Workers, 2 Behavioural Support Ontario Registered Practical Nurses (BSO RPN), Family and Resident Council Representatives, 40+ Residents and 4+ Family Members.

During the course of the inspection, the inspector(s) toured the resident home areas and common areas, medication rooms, the kitchen, the servery, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

Policy on "Medication Administration indicated a) that "the individual who administers the medication dose records the administration on the resident’s MAR directly after the medication is given".

A) The following was observed:

- A Registered Practical Nurse (RPN) was observed to signing a clinical record for an identified resident before giving the medication and reported to the inspector that she "usually" signs the clinical record after she gives the medication but this time she signed it before giving it.

- An RPN was observed signing a clinical record for an identified resident prior to administering medication.

- An RPN was observed signing a clinical record for an identified resident prior to administering the medication. The medication was not observed as given and the inspector left the dining room.

- An RPN was observed signing for a medication for an identified resident prior to administering the medication. Resident refused the medication and the RPN indicated that they will attempt to give it to the resident later. Resident was not offered the medication again before inspector left the dining room.

- An RPN signed for a medication and confirmed that she had not given the medication to the resident.

The expectations were confirmed with the Clinical Coordinator and the Director of Care that staff were to sign the Medication Administration Record after the administration of the drug to ensure that the policy, procedures or system put in place was complied with. (532)

B) The “Falls Prevention and Management Program Policy" directed Registered Nursing staff to initiate Head Injury Routine (HIR) for all un-witnessed falls. A review of the clinical record stated an identified resident had un-witnessed falls. The clinical record and the RPN confirmed that documentation for the un-witnessed falls sustained by the resident were not completed at the times indicated. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails were used, the resident was assessed and bed system evaluated in accordance with evidence-based practises to minimize risk to the resident.

A) An identified resident was observed in bed with two quarter rails in the raised position.(532)

B) An identified resident was observed in bed with two quarter side rails in the raised position.(568)

C) An identified resident was observed sleeping in bed with both quarter bed rails in the raised position.

A review of the clinical records stated there were no assessments completed for the use of bed rails for the above residents and the Assistant Director of Care confirmed that the residents currently were not assessed for bed rails. [s. 15. (1) (a)]

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 where bed rails are used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practises to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of the clinical record stated the following:

- An identified resident had impaired skin and there was no assessment completed by the registered nursing staff and this was confirmed by a Registered Nurse.

- An identified resident had impaired skin. A review of the clinical record stated that there was no skin assessment completed by a member of the registered nursing staff and this was confirmed by a Registered Nurse.

- An identified resident had impaired skin. A review of the clinical record indicated that there was no skin assessment completed by a member of the registered nursing staff.

The Clinical Co-ordinator confirmed that assessment completed by members of the registered nursing staff was not completed using a clinically appropriate assessment instrument. The Clinical Co-ordinator confirmed the home was in the process of developing a new process related to skin assessments. [s. 50. (2) (b) (i)]

2. The licensee of the long term care home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A review of the clinical record stated the following:

- An identified resident had altered skin integrity. There was no weekly reassessment completed by a member of the registered nursing staff and this was confirmed by a Registered Nurse.

- An identified resident had altered skin integrity, however, there was no weekly reassessment completed by a member of the registered nursing staff and there was no documentation noted for the identified weeks.

Registered staff confirmed that the weekly reassessment was not completed for the identified residents. [s.50.(2)(b)(iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A) A review of the clinical record for an identified resident indicated that resident required half bed rails while up in bed, the bed was to be kept in the lowest position and fall mats were to be placed around the bed. The resident was observed sleeping in bed with both rails in the raised position with no fall mats in place. A Personal Support Worker reported that floor mats were not used for this resident as a safety intervention. [s.6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A review of the clinical record for an identified resident indicated that the resident had an assistive device that was to be placed in the resident's room where the resident sits. The resident was observed in their wheel chair with no assistive device in place. A Personal Support Worker reported that the resident did not use the assistive device and the RPN confirmed that the resident was required to have the assistive device but it was not in place.

B) A review of the clinical record for an identified resident stated a specific toileting schedule. The resident confirmed that they were not toileted at the scheduled time. An RPN and a PSW both reported different toileting times for the resident. The Restorative Care Coordinator confirmed that the resident was on a specific toileting schedule and the times were determined through an assessment and that staff were to follow the toileting schedule as specified in the plan.

C) A review of the clinical record for an identified resident stated that a treatment was to be administered. In an interview an RPN confirmed that a treatment was not offered to the resident and care was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that the home was equipped with a resident staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

A) The following were observed:

- An identified resident was sleeping in bed and the call bell was located on the floor at the head of the bed. The call bell was not easily seen and accessed at the time of observation.

- An identified resident was laying in bed and the call bell was wrapped around the bed rail at the head of the bed. The resident confirmed that they were unable to reach the call bell to access. The clinical record indicated that the call bell was to be pinned to the resident at all times.

- An identified resident was laying in bed and the call bell was as not accessible. A Personal Support Worker had to raise the bed and kneel down to pull the call bell out from under the bed. The staff member confirmed this was not accessible for staff and visitors to activate.

- An identified resident was laying in bed and the call bell was wrapped around at the top of bed rail. The resident confirmed that they could not reach the call bell and reported that they were looking for it as they required staff assistance.
A Personal Support Worker and the resident confirmed that the call bell was not easily seen and accessible for resident, staff and visitor use. [s. 17. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the allegation of resident abuse that resulted in harm, and the information upon which it was based, to the Director.

A) An identified resident reported to the Clinical Coordinator that a staff member had been rough. It was verified through resident and staff interviews and the clinical record that there was an injury. The Director of Care confirmed that the alleged allegation of abuse was not reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized program for Responsive Behaviour that includes:
goals and objectives; relevant policies, procedures, protocols; methods to reduce risk; methods to monitor outcomes, and protocols for referral of a resident to specialized resources where required.

A) A review of the Homes' programs related to Responsive Behaviours identified the following policies:
"Wandering/Confused Residents", "Care of Aggressive Residents" and a policy specific to the "Semi-Secure Home Area."
The policies did not include a description of the behaviour program and did not reference specific goals, objectives, protocols or monitoring of outcomes.

The Assistant Director of Care confirmed that there was no formalized Responsive Behaviours program that included a written description with goals, objectives, relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. [s. 30. (1) 1.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of the clinical record indicated the following:

- An identified resident had one bath documented for a specific time frame. It was reported by staff that the resident refuses baths however, the clinical record did not indicate the refusals on the identified days and a Personal Support Worker reported that staff forget to document on the clinical records.

- A review of clinical record for an identified resident indicated that the resident did not have documentation completed when baths were provided or refused. This was confirmed as there were missing entries in the clinical record and no documentation was noted that indicated that the resident had completed or refused a bath. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that a resident of the home received fingernail care, including the cutting of fingernails.

A) An identified resident was observed to have long, uncut, fingernails. The resident confirmed that they were too long and the RPN confirmed that the fingernails were long, jagged and required nail care.[s. 35. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except,
as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident,

A) An identified resident indicated that they self-administer and keep a medication in their room in a locked cabinet.
A review of the clinical record stated that there was no physician's order to indicate that the resident was permitted to keep the drug in their room. The Director of Care confirmed that there was no physician’s order to authorize the resident to keep the drug in their room. [s. 131. (7)]

Issued on this 30th day of June, 2014

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