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
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Original Public Report

Report Issue Date: August 1, 2023	
Inspection Number: 2023-1435-0003	
Inspection Type: Critical Incident System	
Licensee: Parkwood Mennonite Home Inc.	
Long Term Care Home and City: Parkwood Mennonite Home, Waterloo	
Lead Inspector Alicia Campbell (741126)	**Inspector Digital Signature** Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.08.01 15:24:39 -04'00'
Additional Inspector(s) Megan Brodhagen (000738)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24-28, 2023

The following intake(s) were inspected:

- Intake #00018087, CI #2952-000004-23 - related to neglect of multiple residents
- Intake #00088519, CI #2952-000013-23 - related to allegations of staff to resident abuse

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that four residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary
At the beginning of their shift, a Personal Support Worker (PSW) found four residents incontinent of bladder and bowel to the extent that they were not clean, dry and comfortable. The PSW stated that these residents did not receive sufficient changes on the previous shift to remain clean, dry and comfortable.

The Associate Director of Care (ADOC) and Continence Lead acknowledged that the residents were not clean, dry and comfortable and appeared to have not received continence care during the previous shift.

When these four residents were not changed as required to keep them clean, dry and comfortable, they were at risk of developing altered skin integrity.

Sources: Critical Incident Report, Parkwood Mennonite Home Investigation Notes, Pictures of residents, Interviews with staff.

[000738]