

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

609 Kumpf Drive, Suite 105 Waterloo, ON, N2V 1K8 Telephone: (888) 432-7901

Original Public Report

Report Issue Date: December 9, 2024

Inspection Number: 2024-1435-0005

Inspection Type:

Critical Incident

Licensee: Parkwood Mennonite Home Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-5, 2024

The following intake(s) were inspected:

- Intake: #00126172 -related to a disease outbreak
- Intake: #00129766 -related to a disease outbreak
- Intake: #00132701 -related to a disease outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)



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Infection prevention and control program s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was followed in the home.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, Revised September 2023, standard 5.6 stated that policies and procedures of the home must indicate how to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and that the licensee was to ensure that surfaces were cleaned at the required frequency.

Rationale and Summary

The home's cleaning and disinfecting principles policy, IC005025.00-reviewed September 19, 2024, did not include procedures to determine the frequency of surface cleaning and disinfection using a risk stratification approach and no procedure for ensuring that surfaces were cleaned at the required frequency.

The Director of Campus IPAC acknowledged that the homes cleaning and disinfecting policy did not include how to determine the frequency of surface cleaning and disinfection using a risk stratification approach or how to ensure surfaces were cleaned at the frequency required.

Sources:

Interview with Director of Campus IPAC, Cleaning and Disinfecting principles policy, ICO05025.00-reviewed September 19, 2024, Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd



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Edition, April 2018, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, Revised September 2023

WRITTEN NOTIFICATION: CMOH and MOH

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

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Ministry of Health, Effective: April 2024 stated alcoholbased hand rubs (ABHR) must not be expired.

Rationale and Summary

ABHR was observed in various locations of resident care areas, with no expiry dates on the bottles. Staff were observed using these bottles of ABHR.

The Director of Campus Infection Prevention and Control (IPAC) stated that they were aware the expiry dates came off of the Aloe Care ABHR bottles.



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Failure to ensure ABHR was not expired may have increased the potential risk for spread of infectious disease pathogens.

Sources:

Observation, interview with PSW #106 and Director of Campus IPAC, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Ministry of Health, Effective: April 2024