



**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**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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## Public Copy/Copie du public

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 6, 2015	2015_325568_0024	019239-15	Complaint

### Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES  
200 Boullee St. New Hamburg ON N3A 2K4

### Long-Term Care Home/Foyer de soins de longue durée

GREENWOOD COURT  
90 GREENWOOD DRIVE STRATFORD ON N5A 7W5

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DOROTHY GINTHER (568)

## Inspection Summary/Résumé de l'inspection



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

**This inspection was conducted on the following date(s): August 31, 2015**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer of the Tri-County Mennonite Homes, the Administrator, Director of Resident Services, Director of Recreation and Volunteers, and the identified residents. The inspector also observed dining service, care provided to the identified resident and other residents, reviewed the clinical records of the identified resident, the home's admission package, and the Residents' Council minutes.**

**The following Inspection Protocols were used during this inspection:  
Dignity, Choice and Privacy**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's right to have his or her lifestyle and choices was fully respected and promoted.

Record review revealed that resident #001 and their Substitute Decision Maker (SDM) raised a concern regarding an activity taking place in the home. The Executive Director spoke with resident #001's SDM regarding their concerns and how they might resolve the issue. The home's Pastoral Advisor and Director of Resident Services met with the resident on more than one occasion to discuss alternatives.

Resident #001 was not satisfied with the alternatives offered by the home and felt that their choices with respect to lifestyle were not being respected.

The licensee has not fully respected and promoted resident #001's right to have their lifestyle and choices respected.

***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 the resident's right to have his or her lifestyle and choices is fully respected and promoted., to be implemented voluntarily.***



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**Issued on this 29th day of October, 2015**

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

**Original report signed by the inspector.**