Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 21, 2021	2021_790730_0012	004145-21	Critical Incident System

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street 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

CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 7, 8, 9, and 12, 2021.

The following Critical Incident (CI) intake was completed within this inspection:

Log #004145-21/ CI 3023-000004-21 related to hospitalization and change in condition.

An Infection Prevention and Control (IPAC) inspection was also completed during this inspection.

A Complaint Inspection #2021_790730_0013 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Personal Support Workers (PSWs), a Registered Nurse (RN), a Housekeeper and a resident.

The inspector also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident related to falls prevention which set out the planned care for the resident, the goal the care was intended to achieve, and clear direction for staff and others who provided direct care to the resident.

A resident was assessed as being at high risk for falls. The resident's written plan of care did not include a section related to falls prevention. The home's policy titled "Falls Prevention" (VII-G_30.0) stated after the completion of the detailed Fall Risk Assessment that the care plan would be updated with the associated risk level and interventions.

A Registered Nurse (RN) said that the resident was at high risk for falls and that interventions related to falls preventions would be documented in the written plan of care on Point Click Care (PCC). They said that they expected that the resident would have a section in their care plan related to falls prevention, but that they did not and that they would add one in. The Director of Care, who was also the lead of the home's falls prevention program stated that it would be their expectation that the resident would have had a section in their care plan related to falls prevention.

There was increased risk of harm to the resident as a result of not have a written plan of care related to falls prevention.

Sources: Care plan and other clinical records for a resident, the home's policy titled Falls Prevention (Last revised September 2019), and interviews with an RN and other staff.

2. The licensee has failed to ensure that plan of care for a resident provided clear direction related to transferring.

A resident plan of care stated that they required a specific method for transferring. During an observation of the resident's room, an Inspector noted that the transfer logo in the resident's room indicated a different method of transfer.

A Personal Support Worker (PSW) said that staff were made aware of a resident's transfer status in their care plan or they used the logos in the resident rooms. They said that the transfer logo in the resident's room was not updated to reflect their current status. The Director of Care (DOC) said that they would have expected that the logo would have been updated to reflect the care required by the resident and that this did not provide clear direction for staff providing care to the resident.

There was increased risk of harm to the resident as a result of the resident's transfer logo not being updated to provide clear direction for staff.

Sources: Care plan and other clinical records for the resident, observations of the resident's room, and interviews with a PSW and other staff.

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.