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

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Original Public Report

Report Issue Date: October 3, 2022	
Inspection Number: 2022-1518-0001	
Inspection Type: Critical Incident System	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Greenwood Court, Stratford	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2022.10.07 11:21:50 -04'00'
Additional Inspector(s) Susan Crann (741069)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 27, 2022
September 28, 2022
September 29, 2022

The following intake(s) were inspected:

- Intake: #00007268 - [Critical Incident: 3023-000007-22] Injury of a resident which required transfer to hospital and resulted in a significant change in their health condition.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC# 001 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O.Reg. 246/22, s. 115. (3) 4.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health condition no later than one business day after the incident occurred.

Rationale and Summary
In July, 2022 a resident had an incident that caused an injury which required transfer to hospital and ultimately led to a significant change in their health condition. The Director of Care (DOC) stated during an interview that the Long-Term Care Home was made aware of the significant change in status when the resident returned from hospital the following day.

The DOC stated during an interview that they were late in submitting the critical incident report (CI) to the Ministry of Long-Term Care (MLTC) due to a miscommunication between their self and the Assistant Director of Care.

There was a minimal risk to the resident's safety due to the late reporting of the CI.

Sources: interview with DOC; the resident's progress notes and CI #3023-000007-22.

[721821]