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

London District
130 Dufferin Avenue, 4th Floor
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Original Public Report

Report Issue Date: April 5, 2023	
Inspection Number: 2023-1518-0003	
Inspection Type: Complaint	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Greenwood Court, Stratford	
Lead Inspector Cassandra Aleksic (689)	**Inspector Digital Signature** Cassandra N Aleksic Digitally signed by Cassandra N Aleksic Date: 2023.04.06 12:14:30 -04'00'
Additional Inspector(s) Meagan McGregor (721)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23, 24, 27, 28, 29, 30 & 31, 2023

The following intake(s) were inspected:

- Intake: #00015734 - complaint related to resident care and services

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident using a mechanical lift.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to resident care concerns including, safe transferring and positioning techniques.

A review of the resident's clinical records indicated they required a specific type of care with transfers.

In an interview with staff, it had been identified that the resident had been left attached to a mechanical lift unattended.

A review of the resident's records showed they had been left unattended in a mechanical lift on another occasion.

In an interview with the home's management team, they confirmed, that no resident was to be left unattended in a mechanical lift.

The risk of an accidental fall was increased for the resident when they were left unattended in a mechanical lift two separate occasions.

Sources: Complainant records; the residents records, and interviews with a staff member, the Administrator and the Director of Care [689]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Grounds
The licensee has failed to ensure that a resident who had exhibited altered skin integrity was reassessed weekly.

Rationale and Summary
The Ministry of Long-Term Care received a complaint related to a resident's care, which included concerns specific to skin and wound.

The resident's plan of care was reviewed which showed that the resident's altered areas of skin integrity were not assessed weekly.

A Registered Practical Nurse (RPN) stated that they were the skin and wound lead for the home. The RPN stated that there were factors which may have impacted the staff's ability to complete the skin and wound assessments. They stated that the altered areas of skin integrity were monitored, but they would expect that weekly skin and wound assessments would have been completed.

There was minimal impact to the resident as the pressure areas were monitored and had not worsened as a result of not being assessed.

Sources: The resident's plan of care; and interview with a RPN [689]