Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
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Original Public Report

Report Issue Date: November 28, 2023
Inspection Number: 2023-1518-0005
Inspection Type: Complaint Critical Incident
Licensee: Tri-County Mennonite Homes
Long Term Care Home and City: Greenwood Court, Stratford

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	
Additional Inspector(s) Samantha Perry (740)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21, 23, 24, 2023

The following intake(s) were inspected:

- Intake: #00093256, CIS #3023-000012-23, related to allegations of resident neglect.
- Intake: #00093522, complaint related resident care concerns.
- Intake: #00095530, CIS #3023-000015-23, related to allegations of resident neglect.
- Intake: #00096720, complaint related to resident care concerns.
- Intake: #00097905, CIS #3023-000018-23, related to a resident's fall.
- Intake: #00098082, complaint related to resident care concerns and allegations of resident neglect and IPAC concerns.
- Intake: #00101721, CIS #3023-000022-23, related to a resident's fall.

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Infection Prevention and Control
- Staffing, Training and Care Standards
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed rails

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

Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

Bed rails

s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee has failed to ensure that where bed rails were used for a resident the resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Rational and Summary

The Ministry of Long-Term Care received a resident care complaint specific to a resident's bed.

A clinical record review for the resident showed the resident used bed rails.

In an interview the Administrator said the home's expectation was for when bed rails were used the bed entrapment assessment to be completed upon admission, quarterly, and significant change including change in the bed system. They said the bed entrapment was completed only once since admission.

The resident was not assessed, and their bed system was not evaluated when they were using bed rails which put the resident at risk.

Source: record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Safe transferring

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rational and summary
The Ministry of Long-Term Care received a complaint and a Critical Incident System report related to allegations of unsafe transfers of a resident.

The resident's plan of care included specific directions for staff related to safe transfers.

In an interview the Administrator said the expectation was for the staff to use safe transferring techniques.

The resident was put at risk when staff did not follow the expected practice for safe transfers.

Sources: record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that when a resident fell they were assessed and a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and summary:
The Ministry of Long-Term Care (MLTC) received a critical incident system (CIS) report related to a fall sustained by a resident.

A clinical record review for the resident documented the resident had a fall resulting in an injury.

A review of the assessments tab in point click care (PCC) showed there was no post fall assessment using a clinically appropriate assessment instrument specifically designed for falls completed for the resident. Potentially, impacting the resident by putting them at risk of unidentified injuries and or the identification of contributing factors when an appropriate assessment instrument was not completed.

An interview with management supported the resident was not assessed using a clinically appropriate post fall assessment instrument. The resident should have been assessed using an appropriate instrument and the home planned to implement this practice in January 2024.

Sources: Resident record review, and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure 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. A clinical record review for the

resident showed the resident's altered areas of skin integrity were not reassessed weekly.

A Registered Practical Nurse that weekly reassessments were not completed weekly. 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 altered areas of skin integrity were monitored and had not worsened as a result of not being assessed on the specific dates.

Sources: record review and staff interviews. [523]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

The licensee failed to ensure all staff participated in the implementation of the Infection Prevention and Control (IPAC) program when providing direct care to a resident.

Rationale and summary:
A record review for the resident documented they were under enhanced precautions, which required staff to don the following personal protective

equipment (PPE), a gown and gloves when providing direct care.

During the course of this inspection it was observed that staff in the resident's room and the staff who later entered the resident's room to assist with transferring the resident with a lift were not wearing gowns. Furthermore, after staff had completed the resident's direct care, they exited the resident's room with the lift and left it unattended in the hallway without first cleaning the lift. This did not impact the resident; however, there was a potential risk to the resident and their co-residents of cross contaminated acquired infection when proper PPE was not donned by staff and the used equipment was not cleaned before being left unattended.

Interviews with staff and IPAC lead supported staff were expected to wear gowns when providing direct care to any resident with specific precautions. And to clean the lift and or any other resident shared equipment before leaving it unattended and available to other staff members to use in an effort to decrease or eliminate the risk of cross contamination.

Sources: Resident record review, observations and interviews with staff and the home's IPAC lead. [740]