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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Public Report

Report Issue Date: January 7, 2025

Inspection Number: 2024-1518-0005

Inspection Type:
Critical Incident
Follow up

Licensee: Tri-County Mennonite Homes

Long Term Care Home and City: Greenwood Court, Stratford

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 2, 3, 6, and 7, 2025.

The following intakes were inspected:

- Intake: #00129159 - Follow-up #1 - Compliance Order (CO) #001 from inspection #2024-1518-0004
- Intake: #00129160 - Follow-up #1 - CO #002 from inspection #2024-1518-0004
- Intake: #00130882 - Critical Incident (CI) #3023-000025-24 regarding an infectious disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1518-0004 related to O. Reg. 246/22, s. 12 (1) 1. i.

Order #002 from Inspection #2024-1518-0004 related to O. Reg. 246/22, s. 12 (1) 2.

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

Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director, was complied with.

In accordance with section 4.3 Outbreak Preparedness and Management under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure that a summary of the findings from an outbreak debrief meeting was created, which would have provided recommendations to the licensee for improving the home's outbreak management practices.

Sources: review of outbreak CI #3023-000025-24, and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure they followed the Ministry of Health's (MOH) Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024.

1) These recommendations require that alcohol-based hand rubs (ABHR) must not be expired. During an inspection, expired ABHR was used for resident hand hygiene.

2) In accordance with MOH recommendations the licensee is to conduct weekly Infection Preventions and control (IPAC) audits during an infectious disease outbreak, as recommended by the Chief Medical Officer of Health. During an inspection, the IPAC Lead identified that some weekly IPAC audits were missed during an outbreak.

Sources: observations, record reviews, and staff interviews.