Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2016	2016_303563_0004	005888-16	Resident Quality Inspection

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St. 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

MELANIE NORTHEY (563), REBECCA DEWITTE (521), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 2-4 and 7-9, 2016

The following inspection was conducted concurrently during this RQI inspection: Critical Incident: C593-000006-16 / Log #007329-16

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Director of Resident Services, the Dietitian, the Resident Assessment Instrument Coordinator, three Registered Nurses, one student Registered Practical Nurse, five Personal Support Workers, one Hairdresser, three family members, the Resident Council President and 40 residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 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	Legendé 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Record review revealed resident #002 did not have a specific intervention documented in the plan of care after a fall. The plan of care was not revised to include the use of this specific intervention when the fall occurred.

The record review also revealed resident #002 was incontinent. Observations revealed the plan of care posted in the resident private bathroom described the resident's specific toileting routine without the use of an incontinent product.

An interview with the Personal Support Workers (PSWs) #109 and #110 revealed the resident required the use of an incontinent product.

An interview with the Director of Care (DOC) #101 confirmed the plan of care for resident #002 was not reviewed and revised when the care needs changed and it was the home's expectation that the resident was to be reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. A record review of the current care plan for resident #049 revealed the resident required staff assistance for all transfers due to an injury. The care plan also revealed that the resident was not allowed to weight bear. Observations of resident #049 revealed the resident was able to weight bear comfortably.

An interview with the DOC #101 confirmed the plan of care was not revised and updated when the resident care needs had changed as the resident had been able to weight bear and confirmed it was the home's expectation that residents were reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

3. Observation of resident #021 revealed the resident was sitting in a manual wheelchair with the use of a restraint.

Record review of the “Restraint Alternative Checklist” for resident #021 revealed the restraint had been discontinued.

Record review of the current plan of care for resident #021 revealed the use of the restraint.

Interview with Registered Nurse (RN) #103 confirmed resident #021 no longer used the restraint on the wheelchair as it was discontinued. The RN confirmed that the care plan was not updated when the care needs changed. [s. 6. (10) (b)]

4. Observation of resident #043 revealed the resident used a mobility device as the primary mode of locomotion. Observations revealed the resident was lying asleep in bed with a specific fall intervention in place. There was two mobility devices in the resident's room.

Record review of the current care plan for resident #043 revealed staff were to remind the resident to use one of the devices, however the resident does not use this device for any mobility tasks anymore.

The plan of care was not updated to reflect the resident's current physical functioning related to mobility and walking. The care plan also did not mention the use of a specific falls prevention strategy. Staff interview with PSW #114 confirmed the resident did not walk and the resident no longer used one of the mobility devices.

Staff interview with RN # 105 confirmed that the care plan should have interventions related to the use of a specific falls prevention strategy and confirmed the care plan was not revised and updated when the resident's care needs changed.

Staff interview with the DOC # 101 confirmed the resident has not been physically able to use one of the mobility devices for months. The DOC shared it was the home's expectation that the plan of care for all residents were to be reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Record review of the Annual Minimum Data Set (MDS) Assessment revealed behavioural symptoms were documented as occurring for resident #043. Record review of the Quarterly MDS Resident Assessment Protocols (RAPs) Assessment revealed resident #043 demonstrates specific responsive behaviours that require documented interventions in the plan of care.

Record review of the current care plan revealed there were no specific strategies developed and implemented to respond to resident #043 demonstrating responsive behaviours.

Staff interview with Personal Support Worker (PSW) # 114 confirmed the resident does present responsive behaviours.

Staff interview with the Registered Nurse (RN) # 105 confirmed there were no interventions in the current care plan related to the resident's responsive behaviours. The RN confirmed the care plan should have strategies developed and implemented to respond to resident # 043.

Staff interview with the Director of Care (DOC) # 101 confirmed resident #043 has been demonstrating responsive behaviours since admission and confirmed it was the home's expectation that strategies were developed and implemented to respond to all residents who have demonstrated responsive behaviours. [s. 53. (4) (b)]

Issued on this 29th day of March, 2016

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

Original report signed by the inspector.