Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 8, 2020	2020_788721_0024	015074-20	Critical Incident System

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street 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

MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 31 and September 1 and 2, 2020.

The following Critical Incident System (CIS) intake was inspected during this CIS inspection:
Log #015074-20, CIS #3023-000002-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN) and three Personal Support Workers (PSWs).

The Inspector also observed staff interactions with residents, the care being provided to residents and falls prevention and management practices in the home; and reviewed clinical records and plans of care for the identified resident and the home's documentation related to the incident.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 oxygen therapy was provided to a resident as set out in their plan of care.

The residents plan of care indicated they required oxygen therapy at all times.

There was a period of approximately 15 minutes where the resident did not receive oxygen therapy and as a result their oxygen levels dropped and there was a change in their condition.

A PSW explained the resident required oxygen therapy at all times and it was the responsibility of PSW staff to ensure the oxygen therapy was in place. The DOC acknowledged that the resident did not receive oxygen therapy for 15 minutes and staff working at this time said they were busy and may have forgot to provide the oxygen therapy.

Sources: Long-Term Care Home’s investigation notes; care plan; progress notes; orders; and interviews with a PSW, the DOC and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that a residents plan of care was reviewed and revised when their transfer needs changed.

A resident fell which resulted in them sustaining a fracture and a change in their condition. The resident required more assistance with transferring after the fall than they did before the fall due to their fracture.

A PSW explained that a residents transfer status would be indicated on the wall in their room and in their care plan. They confirmed that the resident required more assistance with transferring after the fall than they did before the fall. An RPN indicated that a residents transfer status would be reassessed whenever they had a change in condition and the nurse on duty would be responsible for updating their care plan to reflect any change in their transfer needs.

The residents care plan was not updated to reflect the change in their transfer status when they sustained a fracture and their transfer needs changed.

Sources: CIS #3023-000002-20; care plan; progress notes; and interviews with a PSW, RPN and other staff. [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 that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 8th day of September, 2020

[redacted]

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

Original report signed by the inspector.