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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130 Dufferin Avenue 4th floor
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 21, 2021	2021_790730_0013	004612-21	Complaint

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

CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 7, 8, 9, and 12, 2021.

The following intakes were inspected during this Complaint Inspection:

- Log #004612-21 related to retirement home residents residing in the long term care section of the home.

A Critical Incident Systems (CIS) Inspection #2021_790730_0012 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Executive Director of Corporate Services, a Physician, a Personal Support Worker (PSW), a Registered Nurse (RN), the Director of the South West Home and Community Care Support Services, a Manager of Inspections for the Retirement Homes Regulatory Authority, and a resident.

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that they did not operate more beds in a long-term care home than were allowed under the license for the home.

The Ministry of Long-Term Care (MLTC) received a complaint from the South West Home and Community Support Services Director related to three retirement home residents residing in the long-term care (LTC) home. The complainant stated that the retirement residents had been moved to the LTC section of the home and were being provided with care by the LTC staff.

Client records provided by the South West Home and Community Support Services for the three clients indicated that these clients were accepted for LTC home placement but were currently on the waiting list. Client notes for each of these individuals documented that they were currently living in non-funded LTC beds at Greenwood Court. The South West Home and Community Support Services Director stated that their agency had not authorized admission for these three clients to Greenwood Court LTC home.

According to the Long-Term Care Homes Act, 2007, “resident” means a person admitted to and living in a long-term care home.

Greenwood Court Long Term Care Home had one license (#3023-L01) for a total of 45 beds with an expiry date June 30, 2035. At the time of the inspection 42 beds were occupied with 3 additional residents occupying unfunded beds.

Greenwood Court LTC home had two LTC units on the first floor of the home called the Heritage and Colonial units and a retirement home unit on the second floor called the Loft. The home’s census indicated that three clients were currently occupying “unfunded LTC beds” in a LTC unit of the home.

A review of the Residency Agreements for the three clients indicated that these clients had selected the home’s “Advanced Care Plus Package,” which noted that it was located in the LTC area of the home and included care such as “daily am/pm care, assistance for eating, portering, washroom assistance, 24- hour registered nursing staff, physiotherapy services, dietician services with therapeutic diets, enhanced recreation programs including dementia and memory care.”

A Personal Support Worker (PSW) said that they worked in the LTC home. They said that the three clients had all moved to the LTC home into unfunded beds because they required additional care. They said that LTC staff on the unit provided care such as

bathing, dining, continence care, and answering call bells for the three clients.

During an interview, a Registered Nurse (RN) told an Inspector that the home had 45 Long Term Care Home beds and three unfunded beds. The said that three clients were currently residing in the unfunded beds on a unit of the LTC home and were provided care by the staff of the LTC home. The said that the registered staff from the LTC section of the home provided treatments and administered medication to those clients as well as to LTC residents. They said that clients in the unfunded beds were considered LTC residents and received the same care as residents in the funded beds.

A Physician said that they provided care for the three clients in the unfunded beds of the home as well as the residents of the LTC home. They said they had recently completed paperwork for one of the clients to be considered for admission to a funded bed in the home, but that they were currently on a waiting list.

An Inspector observed LTC staff providing care to the three clients including portering, transferring, hand hygiene, housekeeping services, and administering medications. These clients were also observed to be seated in the dining room in a LTC unit during the lunch meal.

The Executive Director (ED) said that the home had three unfunded beds that were currently located in the home. They said that they had 45 bed licenses currently and that three of those beds were currently empty. They said that the home had more physical beds than were licensed for LTC. They said that three clients were currently in unfunded beds and were awaiting placement in LTC. They said that these clients received care provided by the LTC staff but were charged at a higher, retirement home rate and were considered retirement home residents.

The West Home and Community Support Services Director stated that Greenwood Court did not currently have a temporary license to operate additional beds.

A Retirement Homes Regulatory Authority Inspection Manager said that they expected that retirement home residents would reside in the retirement home section of the facility and would be provided with care by retirement home staff. The Retirement Homes Act, 2010 defined a retirement home resident as a person residing in a retirement home.

There was increased risk to the three clients, as they were living in the LTC section of the home in unfunded beds, receiving care from LTC staff, but paying a higher retirement

home rate.

Sources: Clinical records for the three clients including Residency Agreements, Home and Community Support Services Case Notes and Client Information, the Home's License, Observations of the three clients, Interviews with a PSW, RN, and other staff. [s. 104. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 29th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CHRISTINA LEGOUFFE (730)
Inspection No. / No de l’inspection :	2021_790730_0013
Log No. / No de registre :	004612-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 21, 2021
Licensee / Titulaire de permis :	Tri-County Mennonite Homes 200 Boullee Street, New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	Greenwood Court 90 Greenwood Drive, Stratford, ON, N5A-7W5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Joyce Penney

To Tri-County Mennonite Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Order / Ordre :

The licensee must be compliant with s. 104 (1) of the Long-Term Care Home's Act, 2007.

Specifically,

a) the licensee must not operate more beds in the long-term care home than are allowed under the license for the home or under the terms of a temporary license issued under section 111 or a temporary emergency license issued under section 112.

b) the licensee shall arrange safe alternate placement for the three clients in a location other than the LTC home, unless placed in LTC by the placement co-orrdinator.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that they did not operate more beds in a long-term care home than were allowed under the license for the home.

The Ministry of Long-Term Care (MLTC) received a complaint from the South West Home and Community Support Services Director related to three retirement home residents residing in the long-term care (LTC) home. The complainant stated that the retirement residents had been moved to the LTC section of the home and were being provided with care by the LTC staff.

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home placement but were currently on the waiting list. Client notes for each of these individuals documented that they were currently living in non-funded LTC beds at Greenwood Court. The South West Home and Community Support Services Director stated that their agency had not authorized admission for these three clients to Greenwood Court LTC home.

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An Inspector observed LTC staff providing care to the three clients including portering, transferring, hand hygiene, housekeeping services, and administering medications. These clients were also observed to be seated in the dining room in a LTC unit during the lunch meal.

The Executive Director (ED) said that the home had three unfunded beds that were currently located in the home. They said that they had 45 bed licenses currently and that three of those beds were currently empty. They said that the home had more physical beds than were licensed for LTC. They said that three clients were currently in unfunded beds and were awaiting placement in LTC. They said that these clients received care provided by the LTC staff but were charged at a higher, retirement home rate and were considered retirement home residents.

The West Home and Community Support Services Director stated that Greenwood Court did not currently have a temporary license to operate additional beds.

A Retirement Homes Regulatory Authority Inspection Manager said that they expected that retirement home residents would reside in the retirement home section of the facility and would be provided with care by retirement home staff. The Retirement Homes Act, 2010 defined a retirement home resident as a person residing in a retirement home.

There was increased risk to the three clients, as they were living in the LTC section of the home in unfunded beds, receiving care from LTC staff, but paying a higher retirement home rate.

Sources: Clinical records for the three clients including Residency Agreements, Home and Community Support Services Case Notes and Client Information, the Home's License, Observations of the three clients, Interviews with a PSW, RN, and other staff. [s. 104. (1)]

An order was made by taking the following factors into account:

Severity: Actual risk of harm was identified related to the three clients were being cared for by the LTC home staff but they had not been authorized for admission by the placement co-ordinator.

Scope: The scope of this issue was isolated as it related to three out of 48 beds in the home.

Compliance History: One Voluntary Plan of Correction (VPC) and two Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months.

(730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christina Legouffe

Service Area Office /
Bureau régional de services : London Service Area Office