

**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 2, 2021	2021_790730_0030	006990-21, 008035-21	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

CHRISTINA LEGOUFFE (730)

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, 2021.

The following Critical Incident System (CIS) intake was completed within this inspection:

CIS #3023-000005-21/Log #008035-21 related to falls prevention.

The following follow up inspection was also completed:

Log #006990-21- Follow up to CO #001 from inspection 2021_790730_0013/ 004612-21 regarding s. 104. (1), CDD Aug 05, 2021

An Infection Prevention and Control (IPAC) inspection was also completed as part of this inspection.

A cooling and air temperature inspection was also completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Maintenance Lead, a Housekeeper, a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and residents.

The inspectors 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 the home's temperature records.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Falls Prevention

Infection Prevention and Control

Safe and Secure Home

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

**1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 104. (1)	CO #001	2021_790730_0013		730

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature
Specifically failed to comply with the following:**

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, and one resident common area on every floor of the home once every evening or night.

A review of the home's temperature records for August 2021, identified that the home was not measuring and documenting in writing the air temperatures at least once every evening or night.

In an interview with the Director of Care (DOC), they confirmed that the home was not measuring the air temperatures every night or evening.

There was minimal risk of harm to residents related to the air temperature not being monitored in the evening or night.

Sources: The Long Term Care Home's temperature records; and interviews with the DOC and other staff. [s. 21. (3)]

Issued on this 2nd day of September, 2021

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

Original report signed by the inspector.