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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2018	2018_750539_0004	001740-17	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

Nithview Home
200 Boullee Street New Hamburg ON N3A 2K4

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

VALERIE GOLDRUP (539)

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): June 26, 27, 28, 29, July 03, 04, 05, and 06, 2018

During the course of the inspection the inspector toured the home, observed resident care and services, reviewed relevant documents including but not limited to: clinical records, and the home's documentation and procedures as related to the inspection, and interviewed staff.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, a Physician, a Resident Life Coordinator, a Minimum Data Set - Resident Assessment Instrument (MDS-RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Housekeeping Staff, and Residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) A review of Resident #004's progress notes from September to October, 2016, noted that resident #004 had a number of different skin alterations.

No completed treatment directions could be located in the Medical Directives, Medication Administration Record or Treatment Administration Record for any of the skin alterations. Registered staff completed a record review with the inspector and were unable to locate any completed treatment orders in these records.

The policy entitled "Skin and Wound Care Management Protocol Policy #: VII-G-10.80", last revised April, 2016, stated that with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff were to provide immediate treatment and interventions to reduce pain, promote healing and prevent infection as required and to update the plan of care, including the Treatment Administration Record and care plan as appropriate.

On July 6, 2018, the Director of Care confirmed that the expectation of the home is that treatment orders be started for any altered skin integrity on initial identification of the area and at a minimum of weekly thereafter.

B) A Minimum Data Set - Resident Assessment Instrument- (MDS-RAI) Significant Change in Status Assessment dated September, 2016, for Resident #004; triggered a new Resident Assessment Protocol (RAP) for Pressure Ulcers. The RAP stated that resident #004 was at an increased risk for altered skin integrity and that interventions to prevent this were to be added to the care plan. The care plan dated September, 2016, for resident #004 did not include information regarding altered skin integrity interventions.

Registered staff completed a record review with the inspector and were unable to locate any plan of care related to resident #004's potential for altered skin integrity.

The policy entitled "Skin and Wound Care Management Protocol Policy #: VII-G-10.80",last revised April, 2016, stated that registered staff should document in the individualized plan of care any skin care measures.

On July 6, 2018, the Director of Care confirmed that the care plan had not been updated for resident #004 related to their potential for altered skin integrity though it had been documented that it would be.

The licensee failed to ensure that the plan of care provided clear direction to staff on the

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 plan of care sets out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Progress notes for resident #004 from September, 2016, to October, 2016 noted a number of different skin alterations.

During this time period one Head to Toe Assessment was completed in October, 2016. Registered staff completed a record review with the inspector and were unable to locate any other assessments in resident #004's plan of care.

The policy entitled "Skin and Wound Care Management Protocol Policy #: VII-G-10.80", last revised April, 2016, stated that with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff would conduct a skin assessment.

On July 6, 2018, the Director of Care confirmed that the expectation of the home is that an assessment be completed for any altered skin integrity, on initial identification of the area and at a minimum of weekly thereafter.

The licensee failed to complete a skin assessment for the resident 004's altered skin integrity. [s. 50. (2) (b) (i)]

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 a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

The home received a letter of complaint from resident #004's family member in October, 2016, in regards to the care the resident received in the home. The home's complaint binder for the year 2016 was reviewed. The letter was located in the binder titled Nithview Quality Improv Action Forms, under the October tab.

The home's policy entitled "Complaints Management Program, Policy #XXIII-A-10.40", last revised August 2016, stated that the Executive Director would in the event of a written complaint, immediately forward a copy of the complaint to the MOHLTC Critical Incident and Triage Team (CIATT) as per Ministry regulations, and follow the procedure in the written complaint section.

On July 3, 2018, the Executive Director reviewed the home's submissions in the MOHLTC Critical Incident system from October, 2016 to January, 2017, and was unable to locate the submission. The Executive Director confirmed that the home had not submitted the documentation to the MOHLTC as per the home's policy.

The licensee failed to forward to the Director the complaint letter, related to resident #004's care. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response had been made to the person who made the complaint, i. indicating what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

The home received a complaint letter from resident #004's family member in regards to the care the resident received in the home. The home's complaint binder for the year 2016 was reviewed. The letter was located in the binder titled Nithview Quality Improv Action Forms, under the October tab.

The home's policy entitled "Complaints Management Program, Policy #XXIII-A-10.40", last revised August 2016, stated that the Executive Director or designate would, when addressing a written complaint, provide a written response to the complainant within 10 business days of receipt.

On July 5, 2018, the Executive Director confirmed they were unable to locate any information on what follow-up had occurred in regards to the complaint. The complainant had submitted a second letter to the home in November, 2016, requesting a response. This letter was also submitted and on file with the MOHLTC. When asked, the complainant confirmed that they had not received a written response from the home in regards to the two letters submitted to the home.

The licensee failed to respond to the person who made the complaint to indicate what they had done to resolve the complaint. [s. 101. (1) 3.]

Issued on this 15th day of August, 2018

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

Original report signed by the inspector.