



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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 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 |
|--|---|-----------------------------------|--|
| Aug 14, 2018 | 2018_750539_0005 | 006157-17 | 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



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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:

Contenance Care and Bowel Management

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Sufficient Staffing

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

4 WN(s)

3 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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>Legendé</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. 33. Bathing
Specifically failed to comply with the following:**

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and



more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A telephone complaint was received to the Ministry of Health and Long Term Care (MOHLTC) INFOLINE in March, 2017. The caller stated that the resident's were not getting washed, in any form, two times per week.

The "24 HR. Resident Condition Report" for a home area stated that on specified dates in June and July, 2018, that not all resident baths were done.

Resident #002's 30 day look back of the bath task list and the "24 HR Resident Condition Report" stated that resident #002 did not receive a bath on a specified date in June, 2018.

On July 6, 2018, the 30 day look back of the bath task list for resident #002 was reviewed with Minimum Data Set - Resident Assessment Instrument (RAI-MDS) Coordinator #016. It was unclear as to what other dates the resident had not received their tub bath as it was documented as "not applicable" for 7 out of 10 task questions related for bathing.

The "24 HR. Resident Condition Report" for the month of June for another home area stated that on specified dates in June, 2018, that not all resident baths were done.

Resident #007's 30 day look back of the bath task list and the "24 HR Resident Condition Report" stated that resident #007 did not receive their bath on a specified date in June, 2018, and then received two bed baths at 10 and 14 days later instead. Resident #007's plan of care stated that they preferred a tub bath.

During interviews with two PSWs and two registered staff, they said that the home could be short staff at times and baths were not always completed.

RAI-MDS Coordinator #016, Director of Care # 009, and Executive Director # 008, stated that even when fully staffed for PSWs, not all new PSWs had received training on how to complete a tub bath or shower for the residents.

Director of Care # 009 confirmed that the "Working Short Plan 6-2", dated November 16, 2016, did not address how baths were to be made up when the home was short of Personal Support Workers.



The licensee failed to ensure that the resident's #002 and #007 were bathed, at a minimum, twice a week by the method of their choice. [s. 33. (1)]

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 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:**

- s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
- (a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
 - (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
 - (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

Findings/Faits saillants :



1. The licensee of the long-term care home failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included; (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth.

A telephone complaint was received through the MOHLTC INFOLINE in March, 2017. The caller stated that half of the residents on their unit were not receiving oral care. The Caller also stated that they observed the resident tooth brushes as dry.

Residents #001, #002, and #005 were observed for oral care received by the staff. These residents were unable to be interviewed to ask if their oral care had been provided by staff.

Resident #001's bathroom was observed on the mornings of June 29, July 3, and July 4, 2018 after AM care. The resident's tooth brush was found to be dry on all three observations. Resident #001's plan of care stated the staff were to provide oral care in the morning, at bedtime and as needed.

Resident #002's bathroom was observed on the mornings of June 29, July 3, and July 4, 2018 after AM care. The resident's tooth brush was found to be dry on all three observations. Resident #002's plan of care stated that the resident required the staff to provide repetitive cues and intermittent physical assistance. The plan of care also stated that staff were to take over if the resident tires to ensure the task was well done.

Resident #005's bathroom was observed on the mornings of June 29, July 3, and July 4, 2018 after AM care. The resident's tooth brush was found to be dry on all three observations. Resident #005's plan of care for mouth care stated that for one staff member to provide total assistance for oral care.

On July 6, 2018, Resident Life Coordinator #015 confirmed that oral care for residents would include the cleaning of the gums and mouth. They reviewed resident #001, 002, and 005's bathrooms with the inspector. They confirmed the toothbrushes were dry, and had not been used.

The licensee failed to ensure that residents #001, #002, and #005, who could not brush their own teeth received physical assistance or cueing. [s. 34. (1) (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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes; physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :



1. The licensee of the long-term care home failed to ensure that, (h) residents were provided with a range of continence care products that, (iii) promote resident comfort, ease of use, dignity and good skin integrity.

A telephone complaint was received to the MOHLTC INFOLINE in March, 2017. The caller stated that residents on the night shift were double briefed so that night staff did not have to change the residents as frequently. The complainant stated that this was leading to increased skin breakdown and increase in urinary tract infections.

The "24 HR. Resident Condition Report" for a specified date in June, 2018, stated that resident #008 was found by staff double- padded with incontinent products during morning care.

The next day a memo written by Registered Nurse (RN) #017 stated that the double padding of residents was not acceptable and outlined the risk associated with double padding of incontinence products. The memo stated the risk of increased potential for pressure ulcers and urinary tract infections.

On July 6, 2018, Director of Care #009 confirmed that it was the expectation of the home that residents were not double briefed.

The licensee failed to ensure that resident #008 was provided with continence care products that promoted resident comfort, ease of use, dignity and good skin integrity. [s. 51. (2) (h) (iii)]

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 residents are provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning



Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

On a specified date in June, 2018, resident #003 stated that they had not received an offer of water in the evenings by PSWs over the last few weeks. They said that some of the new employees did not know the evening routine and did not come to their room to provide them with water.

The "24 HR. Resident Condition Report", for specified dates in June, 2018, stated resident #003 was upset and had complained that they did not receive their water in the evenings.

A progress note for resident #003 for a specified date in June, 2018, stated the family had also voiced a concern that the resident had told them that they were not receiving their evening drink. The progress note also stated that the resident liked to have water in their room at night.

The resident #003's care plan stated for staff to ensure after dinner snacks were to be delivered to the resident and staff were to report to the charge nurse if the resident refused them.

On July 6, 2018, DOC #009 stated that she had not been made aware of any concerns with the evening snack pass and beverages not being delivered to residents.

The licensee failed to ensure the resident #003 was offered a beverage in the evening after dinner. [s. 71. (3) (b)]



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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.