Ontario

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

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

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

**Rapport d'inspection prévue 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**

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 6, 2019 | 2019_755728_0001 | 032454-18 | 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

Nithview Home
200 Boullee Street New Hamburg ON N3A 2K4

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

MARIA MCGILL (728)

## 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): January 7-9, 2019.**

**The following intakes were completed in this Critical Incident System (CI) Inspection:**

**Log #032454-18**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer of Tri-County Mennonite Homes/Acting Executive Director (Acting ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), the Director of Nutrition Services (DNS), the Office Manager, the Registered Dietitian (RD), Behaviour Support Ontario Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and the Staff Scheduler.**

**The inspector reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, staffing schedules, and manager's meeting minutes.**

**Observations were made of snack service, the home layout, serveries and dining rooms, staff to resident interactions, and relevant residents.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**
**Responsive Behaviours**
**Safe and Secure Home**
**Snack Observation**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding an unexpected death.

Resident #001's plan of care identified a history of specified behaviours. Resident #001's plan of care also documented a history of identified eating patterns that required specified interventions.

In an interview with DOC #101 and BSO RPN #111, they said that behaviours and related interventions would be documented in the care plan. BSO RPN #111 said that behavioural strategies were also documented in the BSO binder.

The care plan did not identify a specified behaviour or any related interventions.

DOC #101, PSW #104, RPN #105, RPN #106, and BSO RPN #111, said that resident #001 would not be able to remember or appreciate directions and would require staff reminders for an identified intervention.

DOC #101 and BSO RPN #111 said that interventions were not in place related to a behaviour and that interventions should have been in place as the risk to the resident had been previously identified.

The licensee has failed to ensure that strategies were developed and implemented for resident #001 to respond to their behaviour. [s. 53. (4) (b)]

***Additional Required Actions:***

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

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the dietary services and hydration program were evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

In accordance with 30 (1) the licensee of a long term care home shall ensure that 30 (1) 3 is complied with in respect to each of the organized programs required under sections 8 to 16 of the Long-term Care Homes Act, 2007.

An annual program evaluation of the dietary services and hydration program was not completed by the home.

Director of Nutrition Services #107 said that an annual review of the dietary services and hydration program was not completed during the year of 2018. [s. 30. (1) 4.]

***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 the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: the program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the nutrition and hydration program included the the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding an unexpected death.

The home's dining rooms were observed to have a pass through refrigerator that had a door, that opened into the dining room, and another door that opened into the servery area. Director of Nutrition Services #107 said that prior to this incident the refrigerator door open into the dining room area was not kept locked but the servery doors were kept locked. Acting ED #100 said that family council had requested that the home keep the dining room doors unlocked as resident's preferred the view that it offered.

The home's document titled Nithview Weekly Manager's Meeting, documented an identified concern related to the dietary areas of the home. There was documented discussion regarding this space. The weekly manager's meeting included discussion of potential options to mitigate risk. The identified risk was not further discussed in the home and interventions were not implemented to mitigate the identified risk.

RPN #105, RPN #111, DOC #101, and DNS #107 said that concerns regarding the identified risk to residents had been discussed and that no action had been taken to mitigate the risk until after an incident occurred.

DOC #101 and DNS #107 said that the specified risk had been identified to management but that action to mitigate the risk had not yet occurred.

The licensee has failed to ensure that risks related to nutrition care and dietary services that were identified have related interventions implemented to mitigate or manage these risks. [s. 68. (2) (c)]

***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 nutrition and hydration program included the the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home had a snack service that included a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences.

A) The dietary lists attached to the snack cart obtained the following information: residents name, resident's location, diet type, diet texture, fluid consistency, diet supplement, and additional directions. The additional directions column included information related to a resident's allergy, portion size, and volume and timing of nutrition supplements. The snack report did not identify any preferences, special needs, level of support, or adaptive aids that the resident may require.

DNS #107 provided the diet type report that would have been on the snack cart related to resident #001 on an identified date. The report included the resident's name, location, and that they had an identified diet order. The report did not identify specific restrictions at snack time that were identified in the resident's plan of care.

PSW #104 said that it was the PSW role to provide the snack cart to residents. DNS #107 said that because they were using the diet type report on the snack cart, interventions identified in PointClickCare (PCC) were not identified on the report located on the snack cart. DNS #107 said that the intervention related to resident #001, was not listed on the diet type report attached to the snack cart.

The home's policy titled directed the Director of Nutrition Services to provide a snack delivery report or other snack report and to verify, at a minimum quarterly, that residents at low and moderate nutritional risk have documentation including special instructions, and that all dietary reports correspond.

B) The plan of care for resident #002 indicated identified preferences. Their plan of care documented a history of low fluid intake.

DOC #101 said that preferences for this resident should have been indicated on the snack list so that staff were immediately aware of residents' needs and preferences during snack pass.

The licensee has failed to ensure that resident #001 and resident #002's special needs and preferences at snack time were included as part of the snack service process. [s. 73. (1) 5.]

***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 home has a snack service that includes a process for food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, to be implemented voluntarily.***

---

**Issued on this 7th day of February, 2019**

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

**Original report signed by the inspector.**

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

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

# Order(s) of the Inspector

# Ordre(s) de l'inspecteur

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MARIA MCGILL (728) |
| **Inspection No. / No de l'inspection :** | 2019_755728_0001 |
| **Log No. / No de registre :** | 032454-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Feb 6, 2019 |
| **Licensee / Titulaire de permis :** | Tri-County Mennonite Homes<br>200 Boullee Street, New Hamburg, ON, N3A-2K4 |
| **LTC Home / Foyer de SLD :** | Nithview Home<br>200 Boullee Street, New Hamburg, ON, N3A-2K4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Sandy Hall |

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

Ontario

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

**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

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

**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 # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The licensee must be compliant with s. 53 (4) (b) of the Ontario Regulation 79/10.

Specifically, the licensee must:
a) Ensure all residents demonstrating responsive behaviours have their behaviours identified with related strategies and interventions developed and implemented to respond to the residents needs.

**Grounds / Motifs :**

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding an unexpected death.

Resident #001's plan of care identified a history of specified behaviours. Resident #001's plan of care also documented a history of identified eating patterns that required specified interventions.

In an interview with DOC #101 and BSO RPN #111, they said that behaviours and related interventions would be documented in the care plan. BSO RPN #111 said that behavioural strategies were also documented in the BSO binder.

The care plan did not identify a specified behaviour or any related interventions.

DOC #101, PSW #104, RPN #105, RPN #106, and BSO RPN #111, said that resident #001 would not be able to remember or appreciate directions and would require staff reminders for an identified intervention.

DOC #101 and BSO RPN #111 said that interventions were not in place related to a behaviour and that interventions should have been in place as the risk to the resident had been previously identified.

The licensee has failed to ensure that strategies were developed and implemented for resident #001 to respond to their behaviour. [s. 53. (4) (b)]

The severity of the issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was determined to be a level 1 as it related to one of three residents reviewed. The home had a level 3 history as they had previous related non-compliance that included:
- written notification (WN) issued June 27, 2017 (2017_610_601532_0003).
(728)

Ontario

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

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

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Apr 12, 2019

## 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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 6th day of February, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Maria McGill

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office