Ontario

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 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

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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
Aug 28, 2019	2019_787640_0022	010928-19, 012087-19, 014600-19, 014827-19	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

HEATHER PRESTON (640)

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 14, 15, 16, 19, 20 and 21, 2019.

During the course of the inspection the LTCH Inspector toured the home, observed the provision of care, reviewed policy and procedure, reviewed clinical records, interviewed residents, family and staff.

The following Critical Incidents (CI) were reviewed:
Log #012087-19 related to alleged neglect of a resident
Log #010928-19 related to responsive behaviours
Log #014600-19 related to a fall of a resident
Log #014827-19 related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with residents, resident families, staffing clerk, Personal Support Workers (PSW), Registered Practical Nurse (RN), Registered Nurses (RN), Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Behavioural Support Ontario (BSO) RPN, Falls Prevention Lead, Continence Care Lead, Assistant Directors of Care (ADOC) and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Critical Incident Response
Falls Prevention
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who had fallen had a post fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls.

On an identified date in July 2019, resident #002 wandered into another resident room and was found on the floor.

Staff completed a Risk Management report used to report all types of incidents. They completed a Post Fall Investigation form that reviewed vital signs, activity at the time of the fall, restraint use, mechanical devices used, mental and physical status prior to the fall, the environmental status at the time of the fall and an area to conduct a medication review.

The Fall Lead was not able to identify a specific post fall assessment instrument that was used in the home. They said the home did attend an RNAO training session off-site related to the Falls Prevention Program but had not reviewed or revised the post-fall documentation instruments based on evidence-based practice or prevailing practice. The Fall Lead had asked the LTCH Inspector where they would find such an instrument.

The DOC told the LTCH Inspector the home did not have a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of every investigation undertaken for every alleged or suspected abuse of a resident by anyone, or neglect of a resident were reported to the Director.

The home submitted two separate Critical Incident (CI) reports to the Director related to suspected or alleged abuse of a resident. In both incidents, resident #002 had wandered into other residents' rooms and was physically hit by those residents.

On an identified date in June 2019, the licensee submitted a CI report to the Director related to alleged neglect of resident #001 by staff.

The DOC said the home had conducted an investigation of the three incidents.

The LTCH Inspector reviewed the most recent CI reports as submitted by the home and they had not been amended to include the results of any investigations.

The DOC told the LTCH Inspector the home had not amended the CI reports, as required, to inform the Director of the results of their investigations. [s. 23. (2)]

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 the licensee must ensure that the results of every investigation undertaken for every alleged or suspected abuse of a resident by anyone, or neglect of a resident are reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #001 and #002 dental status was included in the plan of care.

a) Resident #001 was noted to require dentures upon admission according to home care assessment form. The use of the dentures was captured in the admission Resident Assessment Instrument/Minimum Data Set (RAI/MDS) oral assessment.

PSWs #101, #102 and #103 said the use of dentures was to be included in the kardex to which they had access. Resident #001 was believed to have dentures.

The LTCH Inspector reviewed the clinical record, specifically the plan of care, kardex and task list and the dentures had not been included.

The Director of Care (DOC) stated it was an expectation that the need for dentures be captured in the plan of care and subsequently the kardex.

The DOC acknowledged that resident #001's dental status was not included in the plan of care.

b) Resident #002 was noted to require dentures as per the RAI/MDS assessment.

PSWs #105 said the resident did have dentures and they would review the kardex if they were not sure.

The LTCH Inspector reviewed the clinical record, specifically the plan of care, kardex and task list and the dentures had not been included.

The RAI/MDS Coordinator acknowledged that resident #002's dental status was not included in the plan of care. [s. 26. (3) 12.]

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 the licensee must ensure that residents dental status is included in the plan of care, to be implemented voluntarily.

WN #4: 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 failed to ensure that the annual review of the Falls Prevention Program included the date of the evaluation, a summary of changes made to the program and the dates those changes were implemented.

The LTCH Inspector reviewed the home's annual review of the Falls Prevention Program for 2018 as provided by the DOC.

The review included the Falls Prevention Inspection Protocol (IP) which had been completed by the home.

The date on the evaluation was October 2018 and there were two first names written on the top right-hand corner of the document.

Within the IP, there were three potential changes to the program noted under a "No" answer with no summary of changes made or date of implementation of those changes.

The Falls Lead acknowledged their annual review of the Falls Prevention Program did not include full names, actual date of occurrence, a summary of changes made and the date those changes were implemented. [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 the licensee must ensure that the annual review of the Falls Prevention Program include the date of the evaluation, a summary of changes made to the program and the dates those changes were implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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 failed to ensure that the Responsive Behaviours Program was evaluated and updated annually in accordance with evidence-based practices, or where there were none, in accordance with prevailing practices.

The DOC provided the LTCH Inspector with the annual review of the responsive behaviours program for 2018.

The document was a copy of the Responsive Behaviours IP. In the top right-hand corner were two first names, one of which was RPN #107, the BSO Lead for the home. The date was written as "March 2018".

The IP questions were answered "yes" or "no". If the answer was no, a comment was

hand-written with a potential action to be taken.

The document did not reflect a review of the program related to residents and their responsive behaviour needs based on evidence-based or prevailing practice.

The document did not reflect an actual date the IP was completed, a summary of any changes made to the program as a result of the review or dates that any changes were implemented.

The DOC acknowledged the IP was the only process conducted as the annual review of the Responsive Behaviour Program.

The licensee failed to review their Responsive Behaviours Program in accordance with evidence-based or prevailing practices. [s. 53. (3) (c)]

2. The licensee failed to ensure that when resident #002 demonstrated responsive behaviours, that actions were taken to respond to the needs of the resident including reassessments and interventions and that the resident's responses to the interventions were documented.

Resident #002 had a history of wandering about the home area in their wheelchair including wandering into other residents' rooms.

On identified dates in May, July and August 2019 they had wandered into another resident's room and the other resident struck them causing injury.

On an identified date in June 2019 they wandered into a wheelchair of a female resident who struck out at them.

On an identified date in July 2019 they wandered into another resident's room and was found on the floor.

According to the resident's plan of care, PSWs were to monitor the resident's whereabouts every hour and document that observation. PSWs #110, #111 and #112 said they were to monitor the resident's whereabouts. RPN #106 said that staff were to monitor the resident every hour and that staff did so more frequently than hourly.

PSW #106 and RPN #120 said the intervention for wandering was to put them down the

north hallway where residents were not likely to be in their rooms. They said they routinely checked on resident #002's whereabouts every 15 minutes. If they could not find the resident, it was likely they were in a specific resident room which they felt was okay as the resident was not usually there. They did not document this action or the resident's response to it.

RN #119 told the LTCH Inspector that following an incident they met with staff but did not review what interventions staff had implemented or what interventions had been effective. They said they did not document their discussion with staff.

RPN #120 said that following an incident, they completed a head-to-toe assessment of resident #002 and any other resident involved, they notified the RN, the resident's family and the resident's physician. They said they did not review any interventions implemented or the effectiveness of the interventions with staff.

RPN #107, the BSO Lead for the home, said that staff were not implementing the interventions that had been included in the plan of care. They told the LTCH Inspector that they have not implemented a dementia observation system (DOS) for the resident's wandering behaviour.

During a review of the clinical record, specifically the progress notes, the LTCH Inspector reviewed the BSO referral notes they did not include any review of the resident's interventions on the plan of care, was a review of one to one care that had been provided and directed staff to keep the resident on the north wing and to keep resident #002's hands busy.

The progress notes available to registered staff and the PSW documentation included in POC did not include any reference to interventions implemented or their effectiveness.

ADOC #108 acknowledged staff had not reassessed the resident's needs following incidents, had not documented interventions that had been implemented or the effectiveness of those interventions.

The licensee failed to ensure that actions were taken to respond to the needs of resident #002 when they demonstrated responsive behaviours including reassessment, interventions and documenting resident #002's response to those interventions. [s. 53. (4) (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 the licensee must ensure that:
a) the Responsive Behaviours Program is evaluated and updated annually in accordance with evidence-based practices, or where there are none, in accordance with prevailing practices, and
b) when a resident demonstrates responsive behaviours, that actions are taken to respond to the needs of the resident including reassessments and interventions and that the resident's responses to the interventions are documented, to be implemented voluntarily.

WN #6: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #002, #006 and #007.

A compliance order (CO) related to LTCHA, 2007, s. 6 (7) was issued under Critical Incident Inspection #2019_792659_0011, on June 20, 2019, with a compliance due date (CDD) of September 23, 2019. The following findings are further evidence to support this CO as issued.

a) Resident #002 was assessed to be at high risk for falls. They were always to have

bilateral hip protectors applied. They had been found on the floor of another resident's room on an identified date in July 2019 and had multiple previous falls. There was no documentation to confirm whether the hip protectors were in place at the time of the fall.

Resident #002's plan of care directed staff to apply bilateral hip protectors at all times.

The LTCH Inspector observed resident #002 several times during the inspection process and they did not have their hip protectors applied.

The LTCH Inspector reviewed the PSW documentation related to the use of the hip protectors from August 1 to 18, 2019, inclusive and seven percent (7%) of the required time, there was no documentation indicating the hip protectors had been applied.

PSWs #110 and #115 and RPN #106 said the resident was always to have their hip protectors applied during the day and night. They acknowledged the resident did not have their hip protectors in place on the two specified dates in August 2019.

RPN #106 acknowledged the resident was not provided the care as set out in their plan of care.

b) Resident #006 was assessed to be at moderate risk for falls. They were always to have bilateral hip protectors applied as per their plan of care. They fell most recently on an identified date in August 2019. There was no documentation to confirm whether the hip protectors were in place at the time of the fall.

The LTCH Inspector observed resident #006 on several occasions during the inspection and they did not have their hip protectors applied at either time.

The PSW providing care for the resident had documented the hip protectors had been applied that morning.

The LTCH Inspector reviewed the PSW documentation related to the use of the hip protectors from August 1 to 18, 2019, inclusive and 26% of the required time, there was no documentation indicating the hip protectors had been applied.

PSW #115 and RPN #117 said the resident was always to have their hip protectors applied during the day and night. They acknowledged the resident did not have their hip protectors on an identified date in August 2019.

c) Resident #007 was assessed to be at high risk for falls. They were always to have bilateral hip protectors applied. They fell most recently in July and August 2019. There was no documentation to confirm whether the hip protectors were in place at the time of the fall.

The LTCH Inspector observed resident #007 several times during the course of the inspection. They had one hip protector applied both times.

The PSW providing care for the resident had documented that both hip protectors had been applied that morning.

The LTCH Inspector reviewed the PSW documentation related to the use of the hip protectors from August 1 to 18, 2019, inclusive and 28% of the required time, there was no documentation indicating the hip protectors had been applied.

PSW #109 said the resident was always to have their hip protectors applied during the day and night. They acknowledged the resident did not have both hip protectors on August 19, 2019.

RPN #117 acknowledged that residents #006 and #007 were not provided the care as set out in their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care was documented.

Resident #002 had a responsive behaviour of wandering about the area and into other residents' rooms. On an identified dates in May, June, July and August 2019, resident #002 wandered into other resident's rooms and generally wandered around the home area. As a result they had received injuries from others and had a fall in another resident's room.

The BSO implemented an intervention in the plan of care to monitor the resident's whereabouts every hour beginning October 31, 2018, which was updated to continue each quarterly review. The intervention was to be documented by the PSWs in POC.

RPNs #106 and #120 and PSWs #105, #110, #111 and #112 told the LTCH Inspector that one intervention for resident #002, to prevent altercations or falling, was to frequently monitor the resident's location and to document that it was carried out.

The LTCH Inspector reviewed this documentation for August 1 to 18, 2019, from the hours of 0700 to 2100 hours inclusive. During this time frame, there were a total of 288 required documentation times.

Of the 288 required times, 263 or 91 percent (%) of the time, there was no documentation regarding the hourly monitoring of resident #002.

ADOC #116 said that it was an expectation that the hourly monitoring be documented by the PSWs in POC each hour.

The ADOC acknowledged the provision of care to resident #002 was not documented as required. [s. 6. (9) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with.

In accordance with O. Reg. 79/10, s. 89, the licensee was required to ensure that there was a procedure and process developed and implemented to report and locate resident's missing items.

Specifically, staff did not comply with licensee's policy, "Missing Clothing and Items", policy #VII-C-10.12 with a revision date of April 2016 that directed staff to conduct a search of the resident room and area for the lost item and to assist the family in completing a Missing Clothing and Items form and give the form to the registered staff on duty.

Resident #001's family noted the resident's dentures were missing.

PSW's #101, #102 and #103 were aware the dentures were missing at the time of the resident's death but were not aware if anyone had completed the Missing Items form. They had not personally completed a search and were not aware when the dentures had gone missing.

PSW #102 told the LTCH Inspector the dentures had been located by housekeeping staff some time later.

The DOC was not able to locate a completed missing items form for resident #001's dentures.

The LTCH Inspector reviewed the progress notes which indicated the dentures had been found 11 days after the resident was deceased.

The DOC acknowledged that staff did not follow the policy and process in attempts to locate the missing dentures.

The licensee failed to ensure that their missing items policy was complied in relation to resident #001's missing dentures. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an incident of abuse of a resident by anyone, was immediately reported to the Director.

On an identified date in May 2019 resident #002 wandered into resident #005's room and was struck in the face.

The licensee reported the critical incident to the Director late. There was no after hours call made to the info-line.

ADOC #116 and the DOC acknowledged the report to the Director was submitted late. [s. 24. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a description of an incident with respect to alleged or suspected abuse of a resident by anyone, was included in the report to the Director.

On an identified date in May 2019 the licensee submitted a critical incident (CI) report to the Director regarding abuse of a resident by anyone. The sub-category was resident to resident.

The LTCH Inspector reviewed the CI report. Under the description of the incident, there was a listing of resident initials, ages and pertinent diagnosis. There was no description of the actual incident included in the report.

The LTCH Inspector reviewed resident #002's clinical record, specifically the progress notes, which identified the resident had wandered into another resident's room and was subsequently struck in the face by the other resident.

ADOC#116 had submitted the report to the Director and acknowledged the report did not include a description of the incident. [s. 104. (1) 1.]

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_787640_0022
Log No. / No de registre :	010928-19, 012087-19, 014600-19, 014827-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 28, 2019
Licensee / Titulaire de permis :	Tri-County Mennonite Homes 200 Boullee Street, New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	Nithview Home 200 Boullee Street, New Hamburg, ON, N3A-2K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Eros

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

Ministère de la Santé et 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

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. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must comply with s. 49 (2) of O. Reg. 79/10 of the LTCHA.

Specifically, the home must:
1) Implement the use of a clinically appropriate assessment instrument that is specifically designed for falls and is based on evidence-based or prevailing practice,
2) Keep a record of the evidence-based and/or prevailing practice used to develop the instrument,
3) Train all registered staff in the application and use of this instrument and,
4) Keep a record of that training.

Grounds / Motifs :

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

1. The licensee failed to ensure that residents who had fallen had a post fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls.

On an identified date in July 2019, resident #002 wandered into another resident room and was found on the floor.

Staff completed a Risk Management report used to report all types of incidents. They completed a Post Fall Investigation form that reviewed vital signs, activity at the time of the fall, restraint use, mechanical devices used, mental and physical status prior to the fall, the environmental status at the time of the fall and an area to conduct a medication review.

The Fall Lead was not able to identify a specific post fall assessment instrument that was used in the home. They said the home did attend an RNAO training session off-site related to the Falls Prevention Program but had not reviewed or revised the post-fall documentation instruments based on evidence-based practice or prevailing practice. The Fall Lead had asked the LTCH Inspector where they would find such an instrument.

The DOC told the LTCH Inspector the home did not have a clinically appropriate assessment instrument specifically designed for falls.

The severity of this issue was determined to be level 2, minimal risk. The scope was determined to be level 3, widespread. The compliance history was determined to be level 2, previous non-compliance to other sections.

(640)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 18, 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 28th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

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