

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

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

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
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1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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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
Nov 24, 2021	2021_923751_0005	015455-21	Critical Incident System

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street New Hamburg ON N3A 2K4

Long-Term Care Home/Foyer de soins de longue durée

Nithview Home
200 Boullee Street New Hamburg ON N3A 2K4

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

ROBERT SPIZZIRRI (705751)

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): November 8, 9, 12, and 17, 2021.

The following intakes were completed in this Critical Incident System inspection: Log #015455-21 related to a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Housekeepers, and family members.

During the course of the inspection, the inspectors toured the home, observed resident and staff interactions, infection prevention and control practices, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

**Inspector(s) also present during this inspection:
Kim Byberg (729)**

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication**

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

**2 WN(s)
1 VPC(s)
1 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>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program when they failed to encourage and/or assist residents to perform hand hygiene before and after meal service.

The inspector observed a meal service in the dining room on three resident home areas (RHA).

All three dining rooms had an alcohol-based hand sanitizer (ABHR) accessible at each point of entry/exit.

a) On November 9, 2021, on a specific RHA between 1133 to 1215 hours, 11 out of 13 residents were not encouraged and/or assisted with hand hygiene before their meal.

b) On November 12, 2021, on a specific RHA between 1135 to 1235 hours, three out of seven residents were not encouraged and/or assisted with hand hygiene before their meal.

c) On November 12, 2021, on a specific RHA between 1237 to 1300 hours, eight out of 10 residents were not encouraged and/or assisted with hand hygiene after their meal.

The home's expectation was that staff were to encourage and/or assist residents with hand hygiene before and after meals.

Failure of the home's staff to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents, staff, and others at potential risk of harm.

Sources: Observations on November 9, 2021 and November 12, 2021, Hand Hygiene Policy (dated October 26, 2020); DOC interview, and other staff. [s. 229. (4)]

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
 - (i) that is used exclusively for drugs and drug-related supplies,**
 - (ii) that is secure and locked,**
 - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
 - (iv) that complies with manufacturer's instructions for the storage of the drugs;**
- and O. Reg. 79/10, s. 129 (1).**
- (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure the safe storage of drugs, specifically, that drugs were stored in a medication cart that was secure and locked.

During the inspection, a registered staff was observed completing a medication pass.

The registered staff left the medication cart unlocked in the hallway, three times, while administering medications in the dining room. The medication cart was not in the registered staff's sight. Residents were observed near the medication cart while left unsupervised.

The registered staff acknowledged the medication cart was to be locked.

Failure of the home's staff to lock the medication cart increased the risk of inappropriate access to medications by anyone, putting them at potential risk of harm.

Sources: Observations, Medication Management – Security & Storage policy (dated April 1, 2019); registered staff interview, and DOC interview. [s. 129. (1) (a)]

2. The licensee has failed to ensure the safe storage of drugs, specifically, controlled substances are stored in a separate locked area within the locked medication cart.

During a medication pass, the registered staff left the narcotic bin unlocked, on three occasions, administering medications in the dining room. The medication cart was not in the registered staff's sight. Residents were observed near the medication cart while left unsupervised.

The registered staff was observed locking the medication cart, but the narcotic bin remained unlocked. The medication cart was left unsupervised in the hallway.

The registered staff acknowledged that both the medication cart and narcotic bin were to be locked.

Failure of the home's staff to lock the narcotic bin increased the risk of inappropriate access to controlled substances by anyone, putting them at potential risk of harm.

Sources: Observations, Medication Management – Security & Storage policy (dated April 1, 2019); registered staff interview, and DOC interview. [s. 129. (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 r. 129. (1) Every licensee of a long-term care home shall ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and (iv) that complies with manufacturer's instructions for the storage of the drugs; and (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

Issued on this 24th day of November, 2021

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

Original report signed by the inspector.

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : ROBERT SPIZZIRRI (705751)

Inspection No. /

No de l'inspection : 2021_923751_0005

Log No. /

No de registre : 015455-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Nov 24, 2021

Licensee /

Titulaire de permis : Tri-County Mennonite Homes
200 Boulée Street, New Hamburg, ON, N3A-2K4

LTC Home /

Foyer de SLD : Nithview Home
200 Boulée Street, New Hamburg, ON, N3A-2K4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Steven Harrison

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

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

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must ensure:

A. All residents are encouraged and/or assisted with hand hygiene before and after they eat.

B. All staff are retrained to ensure compliance with resident encouragement and/or assistance with hand hygiene. A record of the training including the date, educator, content and sign off must be maintained at the home.

C. A designated individual(s) conducts, at minimum, daily hand hygiene audits, on rotating resident home areas, meal and snack services. A record of the audit including the date, time, type of service, auditor, and actions taken if any, must be documented for a minimum of one month and be maintained at the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program when they failed to encourage and/or assist residents to perform hand hygiene before and after meal service.

The inspector observed a meal service in the dining room on three resident home areas (RHA).

All three dining rooms had an alcohol-based hand sanitizer (ABHR) accessible at each point of entry/exit.

a) On November 9, 2021, on a specific RHA between 1133 to 1215 hours, 11

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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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

out of 13 residents were not encouraged and/or assisted with hand hygiene before their meal.

b) On November 12, 2021, on a specific RHA between 1135 to 1235 hours, three out of seven residents were not encouraged and/or assisted with hand hygiene before their meal.

c) On November 12, 2021, on a specific RHA between 1237 to 1300 hours, eight out of 10 residents were not encouraged and/or assisted with hand hygiene after their meal.

The home's expectation was that staff were to encourage and/or assist residents with hand hygiene before and after meals.

Failure of the home's staff to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents, staff, and others at potential risk of harm.

Sources: Observations on November 9, 2021 and November 12, 2021, Hand Hygiene Policy (dated October 26, 2020); DOC interview, and other staff. [s. 229. (4)]

A compliance order (CO) was made taking the following into account:

Severity: The licensee did not ensure that staff followed their hand hygiene policy. Failure of the staff to encourage and/or assist residents with hand hygiene increased the risk of infection transmission and could have put residents, staff, and others at potential risk of harm.

Scope: This non-compliance was widespread as all three resident home areas failed to ensure all residents were encouraged and/or assisted with hand hygiene before and after meals.

Compliance History: The home has not had previous non-compliance in the same section of this legislation in the past 36 months.

(705751)

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

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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 :**

Dec 15, 2021

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
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Care Homes Act, 2007*, S.O.
2007, c. 8

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foyers de soins de longue durée*, L.O.
2007, chap. 8

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**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 des Soins de longue durée
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
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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 révision
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 24th day of November, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Robert Spizzirri

Service Area Office /

Bureau régional de services : Central West Service Area Office