Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 31, 2021	2021_729615_0035	015095-21, 017620-21, 018922-21	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

HELENE DESABRAIS (615)

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): December 10, 13, 14, 15 and 16, 2021.

The following intakes were inspected during this inspection:

Log #015095-21 and Log #017620-21 related to prevention of abuse, neglect and retaliation;
Log #018922-21, Compliance Order #001 related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care - Infection Prevention and Control Lead (DOC-IPAC Lead), the Assistant Director of Care - Behavioural Support Ontario Lead (ADOC-BSO Lead), the Assistant Director of Care (ADOC), a Charge Nurse, the Personal Support Worker - Best Practice Spotlight Champion (PSW-BPSC) and the Personal Support Worker - Behavioural Support Ontario (PSW-BSO).

The inspector also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed CIS reports, reviewed the home's internal investigation reports and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_923751_0005	615

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was protected from neglect by staff in the home.

The home's Unit Daily Record indicated that a resident was getting picked up by a family member. The resident's family member returned to the home with the resident before lunch and helped staff with their care and the resident was then assisted by staff with care and put to bed. The staff who provided care to the resident did not communicate the resident's return with other staff members including those on the oncoming shift.

At dinner time, the resident was not brought to the dining room and a Registered Practical Nurse later found the resident in bed. The resident had not received care, and had not been repositioned or monitored for a period of about 0415 hours as staff were unaware the resident had returned to the home area.

The Registered Nurse beginning their afternoon shift did not complete a visual check of the resident when they started their shift as per the home's Shift to Shift Communication Policy. The PSW beginning their afternoon shift did not complete a visual check of the resident to assess safety precautions as per home's Visual; Check of Residents - Beginning of Shift Policy. The casual absence and return of the resident was not recorded in the plan of care nor in the progress notes in Point Click Care.

The Executive Director stated that residents' absences, and return, should be recorded and communicated to staff on their home area.

The staff's failure to communicate with each other and follow the home's policies and procedures posed a risk of harm to the resident.

Sources: The LTCH's investigative notes; Shift to Shift Communication Policy (last reviewed March 28, 2019); Visual; Check of Residents - Beginning of Shift Policy (last reviewed March 28, 2021); the resident's progress notes; and interviews with the ED and other staff.

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 home protects residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 31st day of December, 2021

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

Original report signed by the inspector.