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
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Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
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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
Mar 31, 2022	2022_923751_0007	020390-21	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), APRIL RACPAN (218), JANIS SHKILNYK (706119)

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): March 2-4, 7-11, 14-18 of 2022.

The following intakes were completed as part of the Critical Incident inspection: Log #020390-21 related to a fall resulting in an injury.

A Complaints inspection #2022_923751_0008 were conducted concurrently with this Critical Incident System inspection.

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

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

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

3 WN(s)
1 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. 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 failed to ensure that the head injury routine strategy included in the required falls prevention and management program was complied with for three residents.

Ontario Regulation (O. Reg.) 79/10, s. 48 (1) 1 requires that an interdisciplinary falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that includes strategies to mitigate falls, including the monitoring of residents.

Specifically, the staff did not comply with the home's policy and procedure for Falls Prevention, VII-G-30-00, current revision dated October 2019.

The falls prevention policy #VII-G-30.00 current revision October 2019 stated that a head injury routine will be initiated if a head injury is suspected or if the resident fall is unwitnessed and he/she is on anticoagulant therapy, monitor HIR as per the schedule on the form post fall for signs of neurological changes, i.e., facial droop, behavioral changes, weakness on one side, etc.

Three resident's had an unwitnessed fall. Head injury routine forms were initiated for each resident. Vital signs and/or neurological assessments were not completed, as required, for specific hours during the assessment period. Entries were documented as resident sleeping or missed.

Assistant Director of Care stated that if a resident hit their head, they should be woken up to complete the required assessments.

When vital sign and neurological assessments were not completed for the three identified residents, it posed a potential risk that injuries may not have been identified.

Sources: interviews with Assistant Director of Care, registered staff, record review of the head injury routine-vital signs form for residents, and falls prevention policy #VII-G-30.00, revision date October 2019. [s. 8. (1)]

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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan, as it related to mobility.

A resident fell from their wheelchair during transportation by a staff member. Interventions on the resident's plan of care identified that the resident had specific instructions for how staff should porter the resident. The staff member did not follow the directions which resulted in the resident falling and sustaining an injury. The resident was transferred to hospital.

The DOC said that interventions identified in the resident's plan of care were not followed by the staff member related to mobility.

As a result of staff not following interventions related to mobility in the plan of care for the resident, actual harm occurred as a result of the resident falling.

Sources: Critical Incident System report, resident's progress notes and plan of care, risk management document, DOC interview. [s. 6. (7)]

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 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)., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a head injury routine for a resident was documented.

Progress notes were documented indicating a resident had a fall in which a head injury routine form was to be completed.

The Long Term Care Coordinator and the DOC said that the home was unable to find the head injury routine form for the resident, and therefore, was not able to confirm documentation was completed.

Failing to ensure documentation was completed could have put the resident at harm by not alerting staff to neurological changes with the resident.

Sources: resident's progress notes, interviews with the DOC, Long Term Care Coordinator, assessments, risk management, care plan, policy Falls Prevention, VII-G-30.00 current revision October 2019. [s. 30. (2)] (706119) [s. 30. (2)]

Issued on this 6th day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
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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), APRIL RACPAN (218), JANIS SHKILNYK (706119)
Inspection No. / No de l'inspection :	2022_923751_0007
Log No. / No de registre :	020390-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 31, 2022
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:

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 8 (1) (b)

Specifically, the licensee must:

1) Follow the home's Fall Prevention policy for resident #013, #014, and #015, ensuring the completion of the head injury routine vital sign form including when a resident is asleep.

2) All staff are retrained to ensure compliance with the home's Fall Prevention policy as it relates to the head injury routine vital sign form. A record of the training including the date, educator, content, and staff sign off must be maintained at the home.

3) A designated individual(s) conducts an audit for each fall, ensuring staff are completing the head injury routine vital sign form as outlined in the Fall Prevention Policy. A record of the audit including the date, time, resident, and actions taken if any, must be maintained at the home and documented for three months, or until the order is complied.

Grounds / Motifs :

1. The licensee failed to ensure that the head injury routine strategy included in the required falls prevention and management program was complied with for three residents.

Ontario Regulation (O. Reg.) 79/10, s. 48 (1) 1 requires that an interdisciplinary falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that includes strategies to mitigate falls, including the monitoring of residents.

Specifically, the staff did not comply with the home's policy and procedure for Falls Prevention, VII-G-30-00, current revision dated October 2019.

The falls prevention policy #VII-G-30.00 current revision October 2019 stated that a head injury routine will be initiated if a head injury is suspected or if the resident fall is unwitnessed and he/she is on anticoagulant therapy, monitor HIR as per the schedule on the form post fall for signs of neurological changes, i.e., facial droop, behavioral changes, weakness on one side, etc.

Three resident's had an unwitnessed fall. Head injury routine forms were initiated for each resident. Vital signs and/or neurological assessments were not completed, as required, for specific hours during the assessment period. Entries were documented as resident sleeping or missed.

Assistant Director of Care stated that if a resident hit their head, they should be woken up to complete the required assessments.

When vital sign and neurological assessments were not completed for the three identified residents, it posed a potential risk that injuries may not have been identified.

Sources: interviews with Assistant Director of Care, registered staff, record review of the head injury routine-vital signs form for residents, and falls prevention policy #VII-G-30.00, revision date October 2019. [s. 8. (1)]

An order was made by taking the following factors into account.

Severity: There was potential risk of harm when the head injury routine was not

completed as any neurological deficits may not be identified.

Scope: The scope of this non-compliance was widespread as multiple residents did not have a head injury routine documented per the home's policy.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 r. 8 (1), and 14 Voluntary Plan of Corrections (VPCs) and 27 Written Notifications (WNs) were issued to the home. The licensee was also previously issued seven Compliance Orders (COs), all of which have been complied. (706119)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2022

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

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

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.

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, 8e étage
Toronto ON M7A 1N3
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 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 31st day of March, 2022

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