Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 16, 2023	
Inspection Number: 2023-1501-0003	
Inspection Type: Critical Incident System	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Nithview Home, New Hamburg	
Lead Inspector JanetM Evans (659)	**Inspector Digital Signature** Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2023.04.13 14:38:18 -04'00'
Additional Inspector(s) Megan Brodhagen (000738)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 28 - March 3, 2023, March 6, 2023 - March 10, 2023

The following intake(s) were inspected:

- Intake: #00019081 and #00020370 Alleged staff to resident neglect.
- Intake: #00020448 Alleged staff to resident abuse

The following **Inspection Protocols** were used during this inspection:

Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented. Specifically, they failed to ensure that appropriate signage was posted for additional precautions for residents.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for LTCHs, dated April 2022, stated that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Section 9.1 (e) stated point-of-care signage indicating that enhanced IPAC control measures are in place.

On two days, observations showed two rooms where residents were on additional precautions did not have point of care signage posted outside the resident doors.

The IPAC lead and staff said that point of care signage was to be posted to direct staff to the need for additional IPAC precautions.

In March 2023, Inspectors observed appropriate signage displayed outside of these rooms.

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Date Remedy Implemented: March 6, 2023

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure the Director was immediately notified of incidents of alleged neglect involving two residents.

A) On a specified date in January 2023, a resident alleged they had rang their call bell for assistance and no one attended to assist them.

A critical incident report (CIS) was submitted two days following this incident, to the MLTC related to this concern.

Sources: CIS # 3004-000002-23, Prevention of Abuse and Neglect of a Resident: Version Detail VII-G-10.00 CURRENT REVISION: Aug 2022, Interviews: ED
[659]

B) On a specified date in February 2023, a resident reported to ADOC #111 they had to wait an hour before someone came to assist them with care.

A CIS was submitted to the MLTC for this concern.

The ED acknowledged the CIS were submitted late.

Failure to immediately report incidents of alleged neglect to the Director (MLTC) may result in a missed opportunity to immediately respond to the incident if required.

Sources: CIS # 3004-000002-23, Prevention of Abuse and Neglect of a Resident: Version Detail VII-G-10.00 CURRENT REVISION: Aug 2022, Interviews: ED
[659]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents.

The home's policy of zero tolerance of abuse and neglect directed staff to remove the resident from the abuser, or if that is not possible, remove the abuser from the resident if it is safe to do so. In addition, the policy directed the DOC or designate initiating the investigation to request that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event.

In February 2023, a critical incident (CI) was submitted to the Ministry of Long Term Care (MLTC) which alleged abuse of a specified resident.

A PSW alleged that colleague had taken a photo of the resident during care. They left the resident alone with their colleague and went to report concerns to the RPN.

The home did not request all staff who were involved in the incident or had awareness of the incident to document a written statement as part of their investigation.

Failure to follow the home's policy for zero tolerance of abuse and neglect put the resident at further risk for potential harm when they were left with the alleged abuser.

Sources: Sources: Prevention of Abuse and Neglect of a Resident: Version Detail VII-G-10.00 CURRENT REVISION: Aug 2022, CIS 3004-000006-23, home's investigation, Interviews with ED, ADOC and staff. [659]

WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to carry out every operational or policy directive that applied to the long-term care home.

A Minister's Directive, effective August 30, 2022, directed licensees to ensure that personal protective equipment (PPE) requirements set out in COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units were followed. This guidance document was revised January 18, 2023, and recommendations for PPE use when providing direct care to a resident with suspect or confirmed COVID-19 included:
o a fit-tested, seal-checked N95 respirator (or approved equivalent).
o appropriate eye protection (goggles, face shield, or safety glasses with side protection)
o gown
o gloves

When interacting within 2 metres of residents in an outbreak area, recommended PPE includes:
o a fit-tested, seal-checked N95 respirator (or approved equivalent) and
o appropriate eye protection (goggles, face shield, or safety glasses with side protection)

The home's outbreak management procedures for management of COVID-19, direct staff to follow the COVID-19 Guidance document as listed above.

A) On a specified date in February 2023, an identified PSW entered a room to assist a resident who was on droplet contact precautions for COVID-19. The PSW was wearing eye protection and a mask; they acknowledged they had chosen to not apply the gown.

B) On a specified day in March 2023, two PSW attended a resident who had fallen on the floor of their room. The resident was on droplet contact precautions for a COVID - 19 infection. They requested further assistance to get the resident up and a staff member who was wearing a mask and protective eyewear entered the room without applying a gown or gloves as directed by posted signage. The staff member acknowledged they had not applied the PPE as indicated.

Failure to follow the Minister's Directive for PPE use when providing care to residents who were positive for COVID-19, put residents and staff at risk for potential transmission of pathogens.

Sources: Observations, Minister's Directive August 30, 2022, Tri County Mennonite Homes Outbreak Management Section I: Emergency Management Version: XVIII-I-10.00, 2022-12-30, Interviews with ED, IPAC lead, staff

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WRITTEN NOTIFICATION: Skin and Wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The home's policy for skin and wound directed PSWs to report unusual skin conditions to the registered staff. Registered staff were to complete a skin and wound assessment for any area of altered skin integrity.

On a specified day in February 2023, a PSW identified the resident had an area of altered skin integrity

and notified an RPN. The RPN notified an RN to assess the resident as they could not see the area of concern. The RN said they were told about the area of altered skin integrity. They put a note in the physician's book to follow up. A skin and wound assessment was not completed for the resident until until 6 days later.

The DOC acknowledged a skin and wound assessment had not been completed for the resident when the area of altered skin integrity was identified and it should have been completed.

Not completing a skin and wound assessment for the resident at the time of the identified area of altered skin integrity risked the staff's lack of awareness of an area of concern and may have delayed treatment if necessary.

Sources: Progress notes, care plan, skin and wound assessments, Skin and Wound care VII-G-10.80, June 2017 and interviews with the DOC, ED and staff.
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WRITTEN NOTIFICATION: Orientation training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee failed to ensure that no person in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.

Two agency PSWs stated they had not received training in the items listed above. They said they had received orientation training on the unit related to the home's procedures.

An agency training document provided, documented 39 agency staff hired back as far as 2021. Of those 39 staff 18 were documented as having completed training, but only two of these were trained prior to working on the unit. The remainder of agency staff required the training to be completed.

The ED and DOC informed inspectors that the process was to schedule agency for an 8-4 shift to complete the Surge learning. They acknowledged the staff members had worked prior to receiving the

training.

Failure to ensure that staff were trained prior to working with residents may potentially result in staff not knowing what their role was for reporting concerns related to allegations of abuse or neglect or contravention of a resident's rights.

Sources: Agency training document; interviews with ED, DOC and agency staff.

[659]

WRITTEN NOTIFICATION: Additional training – direct care staff

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee failed to ensure that all direct care staff were provided with training on abuse recognition and prevention.

Review of Surge training documentation for 2022 showed 92.7 percent of staff had completed training related to abuse recognition and prevention. An email related to staff training indicated that no staff had received training on the Residents' Bill of Rights in 2022.

The ED acknowledged not all staff had completed the required training.

Sources: Surge learning 2022, email dated March 15, 2023, interview with ED.
[659]

COMPLIANCE ORDER CO# 001 Communication and Response system

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall
1. Develop, document and implement a procedure related to the use of work phones/call response system. The procedure should include but not be limited to:
-ensuring each PSW has access to a working call/response system and
- a process to follow if that system fails.

2. Ensure all direct care staff are trained on the procedure outline in #1. The training records should be documented and maintained in the home.
3. Complete a weekly audit of all home areas and all shifts to ensure staff are carrying the work phone, the phones are on and functioning correctly. The audit should include the date, the home area, any issues identified and the action taken to address each issue. The audit should be dated and signed by the person completing the audit. The documentation should remain onsite at the home. The audits are to be completed for one month or until the licensee believes they can show compliance has been achieved.
4. Complete a weekly audit of call response times for one resident on each wing of each home area, for each shift to determine if residents are receiving assistance in a timely manner. The audits are to be completed for one month or until the licensee believes they can show compliance has been achieved. The audit should be dated, documented and signed. The audit should remain onsite at the home.

Grounds

The license failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated, where the call was coming from.

Two residents were assessed to require staff assistance with their care.

One resident waited 36 minutes for staff to assist them and when staff did not attend to the resident they self-transferred. The resident questioned why they had not been assisted and were advised the call/response system was not working.

One resident waited approximately 60 minutes prior to staff assisting them with care. The resident was upset with the wait the time and discussed this with the PSW who tended to them.

Both residents expressed concerns to the home related to these incidents.

The call response system for the home did not include an audible overhead paging system. All resident calls for assistance were routed to the PSW phones. If the PSW failed to acknowledge a call, it would ring to them a second time. If they failed to acknowledge the call a second time, it would ring to the RPN on the unit and the PSW. If neither acknowledged the call, it would ring to them again, as well as to the charge RN. If staff did not have access to a functional call/response system, they were not aware of where call signals were coming from when residents activated the system.

A resident told inspector #659 that there had been prior concerns raised in Resident Council meetings about slow response times to resident calls for assistance. The resident said they thought this was due the work phones not always functioning and that the home could use more staff.

Resident council minutes from September 2022, documented ongoing concerns regarding call bells not being answered in a timely manner. The home's response was that a new phone system was to be implemented but no timeframe was given for this transition.

The home's call response policy stated that call bells would be responded to promptly. Any malfunctioning equipment was to be reported immediately to the direct supervisor.

Front line staff, the DOC and ED said there was not one phone available for each PSW to carry. If a phone was on the charger or staff had to change the battery over then the phone was unavailable to staff and would not ring to alert staff a resident required assistance. Additional batteries were said to be available from the nurse. Staff reported that many of the batteries no longer held a charge. They said it may appear to be charged but the charge would only last a brief time and then the phone was not functional. The DOC reported they requested additional phones but this was not approved because the cost. They later requested new batteries and were supplied with one battery for each unit.

Emails exchanged between the ED, DOC and/or IT indicated there had been concerns with the call response system dating back to 2021, and that critical incidents had occurred related to the call/response system malfunctioning.

QIP surveys completed in 2023 by five residents indicated there were concerns about call response times, or staff failing to return to provide assistance.

Both the ED and DOC acknowledged not having a working call/response system put residents at risk of harm as staff would not be aware of where call signals were coming from.

Sources: observations, Resident Council minutes – Sept 7/22, Call Bell response policy VII-H-10.00, Jan 2015, QIP 2023 resident responses, emails from DOC and ED, call response times for residents #002 and #007, interviews with ED, DOC,
[659]

This order must be complied with by May 11, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.