Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: August 21, 2023	
Original Report Issue Date: July 24, 2023	
Inspection Number: 2023-1501-0004 (A2)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Nithview Home, New Hamburg	
Amended By Katherine Adamski (#753)	**Inspector who Amended Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.08.21 15:55:16 -04'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to: reflect the request for an extension to the compliance due dates for compliance orders #001 and #002.

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Lead Inspector Katherine Adamski (#753)	**Additional Inspector(s)** Kaitlyn Puklicz (#000685) Craig Michie (#000690) Brittany Nielsen (#705769) Diane Schilling (#000736)
Amended By Katherine Adamski (#753)	**Inspector who Amended Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.08.21 15:55:46 -04'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to: reflect the request for an extension to the compliance due dates for compliance orders #001 and #002.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12-16, 20-23, 26, 2023

The following CI intake(s) were inspected:
• Intakes: #00019490, #00020565, #00022614, #00022635, #00087629, #00088783, #00089110 - related to allegations of abuse or neglect
• Intake: #00021016 – related to fall prevention and management
• Intake: #00021310 – related to improper care
• Intake: #00084945 – related to an injury of unknown cause

The following Complaint intake(s) were inspected:
• Intake: #00088947 and #00089193 – related to care and services

The following follow-up intake(s) were inspected:
Intake: #00087069 - follow-up to compliance order #001 from inspection #2023_1501_0003 with a compliance due date of May 11, 2023

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2023_1501_0003 related to O. Reg. 246/22, s. 20 (f) inspected by Katherine Adamski (#753).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED 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)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

The resident required a specific type of mobility device, and this was not reflected consistently in their plan of care.

The Director of Care (DOC) acknowledged this information was inconsistent and made the required changes to their plan of care.

Sources: observations, the resident's plan of care, interviews the DOC and other staff. [#000736]

Date Remedy Implemented: June 16, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others who were involved in the different aspects of care for a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary

A resident stated their care preferences to their Medical Physician (MD) and Substitute Decision Maker (SDM). During a follow-up discussion, the resident's SDM informed the Nurse Practitioner (NP) that the resident's care preferences had changed. The NP documented the conversation in the resident's progress notes, however the MD was not aware of the changes and no further care planning occurred.

The resident's condition deteriorated requiring transfer to hospital where they passed away.

When new information related to the residents' plan of care was received, collaboration did not occur to ensure that the different aspects of the plan of care were integrated, consistent, and complimented each other.

Sources: the residents' plan of care, investigative notes, interviews with the DOC and other staff. [#705769]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from emotional abuse by a staff member.

Section 2 (1) of the Ontario Regulation 246/22 (O. Reg. 246/22) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A resident was refusing assistance from a staff member. In response, the staff member became aggressive and physical with the resident including inappropriate verbal remarks.

The Administrator stated that the allegation of abuse was founded.

Sources: the residents' plan of care, investigative notes, interviews with the Administrator and other staff. [#000685]

WRITTEN NOTIFICATION: Licensee Must Comply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023_1501_0003 served on March 16, 2023, with a compliance due date (CDD) of May 11, 2023.

Rationale and Summary

A) The home failed ensure that each Personal Support Worker (PSW) had access to a working call/response system and a process to follow if the system failed.

B) No documentation to substantiate that a weekly audit of the raw data of the call response times to determine if residents were receiving assistance in a timely manner was provided to the inspector.

Failure to ensure that the home was equipped with a properly functioning resident-staff communication and response system continued to put residents at risk of harm because they were not able to reliably communicate with staff that they required assistance, and staff were not able to communicate with each other to ensure residents were receiving care.

Sources: observations, weekly phones audit records, call bell records, interviews with residents and their SDM's, interviews with the Administrator and other staff. [#753]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
CO #001 issued on March 16, 2023, in inspection #2023_1501_0003.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement. Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applies to Long Term Care Homes (LTCH) related to Infection Prevention and Control (IPAC).

Rationale and Summary

The Ministry of Long-Term Care (MLTC) COVID-19 guidance document for LTCH's in Ontario indicated

that homes must conduct regular IPAC self-assessment audits following at a minimum the Public Health Ontario's (PHO) COVID-19 Self-Assessment Audit Tool for LTCHs and Retirements Homes, once a week when in outbreak, and every two weeks when not in outbreak.

The IPAC Lead stated that the home was currently conducting IPAC self-assessment audits using the required tool once per year.

Sources: the MLTC COVID-19 guidance document for LTCHs in Ontario (updated April 3, 2023), the home's PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirements Homes (dated July 2022), interviews with the IPAC Lead. [#753]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee failed to ensure that three residents who required continence care products, had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary

Three residents were incontinent of their bladder, bowels, or both, required continence care products, and total assistance from staff for continence and peri-care.

The three residents were found incontinent and had not received the continence care that was required.

Two residents were emotionally upset because of this incident. All three residents were at risk of developing skin concerns, or complications related to pre-existing skin concerns.

Sources: the residents plan of care and call bell records, interviews with the Assistant DOC (ADOC) and other staff. [#753]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Rationale and Summary

A) A resident had responsive behaviours which put those within close proximity to them at risk of harm.

Triggers and interventions had been identified related to their responsive behaviours. Additionally, staff had reported another trigger that potentially escalated the residents' responsive behaviours, however, this was not included in their care plan.

i) The resident's interventions to mitigate the risk of altercations were not implemented. In response, the resident was triggered and exhibited physically responsive behaviours against the staff member and another resident resulting in a physical altercation.

The co-resident was at risk of being physically injured, and the staff member was injured as a result of their altercation with the resident they were monitoring.

ii) A specific intervention for a resident related to their responsive behaviours was not in place as per their plan of care.

Registered staff acknowledged that they were aware that a specific intervention was not in place and they should have taken action to ensure that the intervention was implemented as per the resident's plan of care.

During the time that the specific intervention was not in place, the resident had a physical altercation with a co-resident resulting in an injury to the co-resident.

Sources: residents' plan of care, investigation notes, interviews with the ADOC and other staff. [#753]

B) A specific intervention for a resident related to their responsive behaviours was not in place as per their plan of care on two separate occasions.

By failing to ensure that the specific intervention was in place, there was risk of harm to this resident and others.

Sources: observations, the residents' plan of care, interview the DOC and other staff. [#705769]

WRITTEN NOTIFICATION: Police Notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged incident of abuse that the licensee suspects may constitute a criminal offence.

Rationale and Summary

A resident's SDM alleged that an injury to the resident was the result of physical abuse. Police were not notified of this incident immediately.

At the time the allegation was brought forward, the DOC suspected that the injury may have been the result of a criminal offence, but missed completing the required form to notify the police.

By failing to report the allegation of abuse immediately to the appropriate police force, the police were unable to respond to the incident in a timely manner.

Sources: the residents plan of care, investigative notes, interview with DOC. [#705769]

COMPLIANCE ORDER CO #01 Skin and Wound Management

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:
1) A Skin and Wound Care Lead is appointed who oversees the Skin and Wound Care program within the home. Record of the staff's name who holds this title should be documented and maintained in the home.

2) Conduct a weekly audit of skin and wound orders for residents on a specified area of the home to ensure that registered staff completed skin and wound care treatment as outlined in the order. This audit should be conducted for a minimum of four weeks. A record of audits must be maintained in the home, and include the date of the audits, the person responsible, and any actions taken for incomplete care and/or documentation.

Grounds

The licensee failed to ensure that a resident who exhibited skin concerns received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary

A resident had an area of skin concern, which staff noted was deteriorating. An order was initiated for the resident to receive daily treatment for the skin concern and an RPN was assigned to provide the treatment.

The RPN did not complete the treatment as indicated on the resident's treatment administration record (TAR) over a three-day period, despite documenting that they had done so.

The residents skin concern continued to deteriorate requiring further treatment. The resident passed away from complications related to their skin concern.

When the RPN falsified documentation, this negatively impacted the resident.

Sources: the residents' plan of care, investigation notes, interview with the DOC. [705769]

This order must be complied with by: September 15, 2023

COMPLIANCE ORDER CO #02 Reporting Certain Matters to the Director

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure they:

1) Educate all direct care staff that work on specified area in the home on the home's prevention of abuse and neglect policy including mandatory reporting requirements per FLTCA, 2021. Document the education, including who attended, the date and the staff member who provided the education.

Grounds

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse and/or neglect of two residents, immediately reported it to the Director.

Pursuant to s. 154 (3) of the FLTCA, 2021, the licensee is vicariously liable for staff members failing to comply with subsection 28 (1) 2.

Rationale and Summary

A) A resident waited an unacceptable length of time for staff to respond to their call bell, while they were incontinent.

The incident of alleged neglect was not reported to the Director until three days later. The DOC said that the incident should have been reported immediately to the Director but was not.

By failing to report the allegation of neglect immediately, the Director was unable to respond to the incident in a timely manner, if required.

Sources: the residents' plan of care, interview with DOC. [#705769]

B) A resident was handled roughly. Staff members who were aware of the incident did not report the allegation of abuse to the Director or to their management.

The Administrator stated the allegation of abuse should have been reported as soon as staff became aware. The allegation of abuse was later substantiated.

The failure to report abuse of a resident immediately delayed the home's ability to investigate the allegations and take appropriate actions to remove the staff member from the home.

Sources: the residents' plan of care, investigative notes, interviews with Administrator. [#000685]

This order must be complied with by September 15, 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.