Ontario

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

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

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

Original Public Report

Report Issue Date: September 29, 2023	
Inspection Number: 2023-1501-0005	
Inspection Type: Complaint Critical Incident Follow Up	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Nithview Home, New Hamburg	
Lead Inspector Diane Schilling (000736)	**Inspector Digital Signature**
Additional Inspector(s) Janis Shkilnyk (706119) Romela Villaspir (653)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5-8, 11-13, & 15, 2023

The following intake(s) were inspected:

- Intake #00084811, Intake #00085120 and Intake #00086178 related to improper care of a resident.
- Intake: #00089724, related to alleged abuse.
- Intake: #00089845 related to alleged abuse.
- Intake: #00089865, Intake: #00096488, Intake: #00089869, Intake: #00089870 related to alleged neglect.
- Intake: #00093025 - Follow-up #: 2 related to communication and response system.
- Intake: #00093236 - a complaint related to concerns regarding continence care and alleged neglect.
- Intake: #00093987 - a complaint related to communication and response system.
- Intake: #00094560 - a complaint related to alleged abuse.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

Previously Issued Compliance Order(s)

Order #001 from Inspection #2023 1501 0003 in relation to O. Reg. 246/22 s. 20 (f) was complied.

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that two residents' right to be treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth, and individuality, was fully respected and promoted.

Rationale and Summary
A) The resident was ringing their call bell for a prolonged period of time because they needed assistance.

When the staff responded to the resident's call bell they found the resident incontinent.

The resident was upset.

The ADOC indicated the personal support workers (PSWs) should have informed the registered staff that they could not respond to the resident's call bell at that time.

The risk associated to staff not responding to a resident's call bell in a timely manner may impact a resident's feelings of dignity and self-worth.

Sources:
The resident clinical health records, the home's investigation notes; Interviews with the resident and staff.
[653]

B) A resident required assistance for transfers.

At times when they would wait too long for staff to come, and the resident would be incontinent.

The resident's call bell records showed that the staff did not respond to their call in a timely manner on multiple occasions.

The Executive Director (ED) said that if staff did not get to the resident in a timely manner, the resident's dignity may be impacted due to incontinence.

Sources:
Resident clinical health records and call bell records; Interviews with residents and staff.
[653]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that a resident's right to be afforded privacy in caring for their personal needs, was fully respected and promoted.

Rationale and Summary
During a meal service a PSW assisted a resident with care. This care was provided in front of other residents.

The ED said that the resident was not afforded privacy, and that the expectation was for the PSW to take the resident back to their room and assist them with care.

Sources:
Residents clinical health records, the home's video surveillance; Interviews with resident and staff.
[653]

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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
There was an allegation of neglect. This was reported, and an internal investigation was started by the home.

There were no documented assessments of the resident related to this incident as required by the homes zero tolerance of abuse and neglect policy.

The home's investigation records did not include a written statement from the staff who were responsible for the resident. The Assistance Director of Care (ADOC) could not provide documentation to demonstrate that the staff were interviewed.

By not following the home's policy, any potential injuries and impact to the resident may not have been identified. Furthermore, accurate information related to what had transpired may not have been captured in the home's internal investigation.

Sources:
The resident clinical health records, the home's investigation notes, Mandatory Reporting for Prevention of Abuse and Neglect of Residents, Nursing Checklist for Investigating Alleged Abuse; Interviews with staff.
[653]

WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions, were documented.

Rationale and Summary

The home required staff to record all pertinent resident care delivery information prior to the end of their shift on the resident's individual record.

A) A resident who required assistance with care had missing documentation in their health record 55 times over a period of time.

The Director of Long-Term Care (DOC) stated that all tasks for POC should be completed with documentation on each shift for each resident.

By not documenting the resident's care, staff would not have been alerted if the resident's care was completed or missed.

Sources:
The resident's plan of care, clinical health records and interviews with staff.
[706119]

B) A PSW documented a resident's care was completed, prior to the actual provision of care. Staff were not able tell whether the care was completed or required based on the documentation.

The ADOC indicated that the home's expectation was for PSWs to document on POC after care had been provided to the resident.

Sources:
The Resident's clinical health records, the home's documentation policy, interviews with staff.
[653]

WRITTEN NOTIFICATION: Oral Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

The licensee has failed to ensure that a resident received oral care to maintain the integrity of the oral tissue that included mouth care, including the cleaning of dentures.

Rationale and Summary
The resident required assistance from staff for mouth care.

The resident was found without mouth care completed.

The resident had declined care; however, the staff did not go back to re-attempt the care later in the shift.

The DOC acknowledged that the resident did not receive care as required.

By not providing the necessary assistance, the resident's good oral hygiene was not maintained.

Sources: The resident's clinical health records, the home's investigation notes; Interviews with ADOC and others.
[653]

WRITTEN NOTIFICATION: Dress

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44

The licensee has failed to ensure that a resident was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

Rationale and Summary
A resident required assistance from staff.

A PSW was not aware the resident needed assistance with dressing.

The resident entered a congregate setting not dressed appropriately for the day.

The ED said that the resident was not assisted by staff with getting dressed as required, and that the home's expectation was for the resident to be dressed appropriately.

Sources:
The resident's clinical health records, the home's video surveillance; interviews with the resident and staff.
[653]

WRITTEN NOTIFICATION: Qualifications of personal support workers

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 52 (1) (a)

The licensee failed to ensure that every person hired by the licensee to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements when a resident was cared for by an unqualified staff.

Rationale and Summary
An unqualified staff member provided personal support services to a resident.

The ADOC stated that the staff member did not have the qualification of a personal support worker and should not have provided services independently to the resident.

When unqualified staff provide care to residents, there was risk that inappropriate or insufficient care was provided.

Sources:
Observations, and interviews with staff.
[000736]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented.

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

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 indicates that at minimum, routine practices shall include a) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact); and (d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

The home's Hand Hygiene policy indicated that hand hygiene consisted of either hand washing or the

use of alcohol-based hand rub. The policy stated that hand hygiene will be practiced before and after performing a procedure or task involving close resident contact, and after removing any PPE.

The home's Personal Protective Equipment policy attachment titled Recommended Steps for Putting on & Taking off PPE indicated that used gloves are to be discarded immediately into waste receptacle.

A PSW entered the room wearing gloves on both hands, carrying a resident's personal care item. After they gave the personal care item to the resident, the PSW doffed their gloves and placed them in their pocket. The PSW did not perform hand hygiene and proceeded to assist another resident.

The ED said that the PSW did not follow the home's IPAC practices, and there was potential risk for the spread of infectious microorganisms.

Sources:
Hand Hygiene policy, Personal Protective Equipment policy, Recommended Steps for Putting on & Taking off PPE attachment; The home's video surveillance; Interview with staff.
[653]

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

The licensee shall:

a) Conduct an audit to ensure on a specific shift care has been completed for the resident. The audit will be completed three times a week, on different days for four weeks or until such time as compliance is achieved. The items identified in the audit at minimum are:
i) Whether staff completed all aspects of care on a specific shift, including continence care as required
ii) Whether a resident refused care and if so, what follow up actions were taken
iii) The date, time, person(s) who conducted the audit, concerns identified, and follow up actions taken should be documented
b) Ensure that the plan of care for a resident includes a re-assessment in relation to their responsive behaviours, prior to making changes to the plan of care.

Grounds

The licensee failed to protect residents from neglect and from physical abuse. Specifically, there was inaction that jeopardized the health, safety, and well-being of residents.

The legislation defines “neglect” as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents (O. Reg. 246/22 s. 7). "Physical" abuse is defined as the use of physical force by a resident that causes physical injury to another resident (O. Reg. 246/22 s. 2).

A) A resident who required assistance with care was found by the next shift with care not completed.

The DOC stated that their care plan had not been followed.

Inaction by the staff lead to potential impact on the resident’s health status when care was not provided.

Sources:
The resident’s clinical records, interviews with staff, the home’s investigative notes, Personal Care, Hygiene and Grooming policy.
[706119]

B) A resident was found by the next shift with specific personal care not completed.

The Director of Long-Term Care (DOC) stated that the resident had not received care.

Inaction by the staff lead to potential impact on the resident’s health status when care was not provided.

Sources:
The resident's clinical records, interviews with staff, the home’s investigative notes, personal care, hygiene and grooming policy.
[706119]

C) A resident was found by the next shift with care not completed.

The DOC stated that the resident had not received care.

The Registered Practical Nurse (RPN) stated that staff were aware to provide care for the resident but

did not comply.

Inaction by the staff lead to actual impact to the resident, as they experienced an alteration to their skin integrity.

Sources:
The resident's clinical records, interviews with staff, the home's investigative notes, personal care, hygiene and grooming policy.
[706119]

D) Two residents had an altercation and one was injured.

The resident had a history of responsive behaviours.

This incident of physical abuse caused actual harm to the resident.

Sources:
Review of resident clinical records, as well as interviews with staff.
[000736]

This order must be complied with by November 8, 2023

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Second follow up for Order #001 from Inspection #2023_1501 0003 in relation to O. Reg. 246/22 s. 20 (f)

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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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.