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
Telephone: (888) 432-7901

# Original Public Report

**Report Issue Date:** October 13, 2023

**Inspection Number:** 2023-1501-0006

**Inspection Type:**
Critical Incident
Follow up

**Licensee:** Tri-County Mennonite Homes

**Long Term Care Home and City:** Nithview Home, New Hamburg

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Kaitlyn Puklicz (000685) | Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2023.10.27 14:02:52 -04'00' |

**Additional Inspector(s)**
Helene Desabrais (615)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27-28, 2023 and October 4-6, 2023

The following intake(s) were inspected:
- Intake: #00091425/3004-000038-23 and Intake: #00092417/3004-000041-23 related to improper care of a resident
- Intake: #00091431/3004-000039-23 related to staff to resident abuse
- Intake: #00095153/3004-000048-23 and Intake: #00095436/3004-000049-23 related to staff to resident neglect

The following follow-up intake(s) were inspected:
- Intake: #00093027 - follow-up to compliance order #001 from inspection #2023-1501-0004 (A2) with a compliance due date of September 15, 2023
- Intake: #00093026 - follow-up to compliance order #002 from inspection #2023-1501-0004 (A2) with a compliance due date of September 15, 2023

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1501-0004 related to FLTCA, 2021, s. 28 (1) 2. inspected by Kaitlyn Puklicz (000685)

Order #001 from Inspection #2023-1501-0004 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by Kaitlyn Puklicz (000685)

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

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

# 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 a resident was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality.

**Rationale & Summary**
A Critical Incident Report (CIR) was submitted to the Director which stated a resident was found in a manner that did not respect their dignity and worth.

As a result of the incident, the resident sustained redness to their skin in a specific area.

An RPN stated the way the resident was found did not abide by the resident's right to be treated with dignity and respect.

**Sources:**

Clinical record for the resident, the Critical Incident Report, interview with an RPN, the homes investigative notes.

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## WRITTEN NOTIFICATION: Plan of care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7).

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in their plan.

**Rationale & Summary**
A resident was found in a manner that indicated they had not received care for a period of time.

The resident did not receive the assistance and care they required as per their plan of care.

An ADOC stated that according to their plan of care, staff should have assisted with multiple aspects of their care during that time frame.

**Sources:**
Clinical record for the resident, the Critical Incident Report, the home's investigative notes, interview with an ADOC.

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## WRITTEN NOTIFICATION: Dining and snack service

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of a resident's diet, special needs and preferences.

In accordance to O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that there was a Nutritional Care and Hydration program that included a process to ensure staff were aware of the residents' diets, special needs and preferences and that the program is complied with.

**Rationale and Summary**

The home's policy "Pleasurable Dining" (last reviewed January 2022), directed registered staff to oversee and monitor all aspects of Pleasurable Dining, including verifying residents received the correct meal and texture as per physician's order.

According to the home, the process of modifying a resident's diet involves the Registered Dietician (RD) entering the change into the resident's care plan, updating the dining servery report, as well as notifying the nutrition manager.

A resident was assessed by the RD and their food texture was modified. The RD documented in the resident's care plan and Kardex to refer to the Medication Administration Report (MAR) for the diet and texture details. Personal Support Workers (PSWs) do not have access to the MAR.

Ten days later, the resident's family member complained to a PSW that the resident had received a meal that was not the same texture as the RD recently assessed them for. The home's Dining Servery Report did not have the updated dietary texture for the resident.

The Executive Director (ED) and the Director of Nutrition Services (DNS) both stated that PSWs do not have access to the MAR and that registered staff are responsible to verify that residents receive the correct meal and texture but this was not completed prior to serving residents.

There was a risk of harm when the resident received the incorrect diet texture.

**Sources:** The resident's clinical record, the Critical Incident Report, the home's policy "Pleasurable Dining" (last reviewed January 2022), home's Dining Selection Tool/Dining Servery Report, interviews with two PSW's, the ED and DNS.

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