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: January 22, 2024

Inspection Number: 2024-1501-0001

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: 2024.01.25 09:33:38 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-9, 15-16, 2024
The inspection occurred offsite on the following date(s): January 10-11, 2024

The following intake(s) were inspected:

- Intake: #00098290 - Follow-up CO #001 from inspection #2023_1501_0005
- Intake: #00098472 - Resident fall resulting in a change of condition

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1501-0005 related to FLTCA, 2021, s. 24 (1)

inspected by Kaitlyn Puklicz (000685)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

Rationale and Summary

A resident was deemed high risk for falls and experienced a significant number of falls in the last year.

The resident's care plan was reviewed and observed to have contradicting information related to their transfer status and gait aid. It did state that the resident was high risk for falls.

Two direct care staff members familiar with the resident were interviewed and both had differing statements about how the resident transfers, what gait aid they use, and whether or not they are at risk for falls.
The Assistant Director of Care (ADOC) #105 stated that the resident's care plan does not provide clear directions to staff who provide them with care, related to their current transfer status and gait aid, and that it needs to be revised.

When the resident's care plan was not updated with accurate and clear direction for staff, it placed the resident at risk of injury.

Sources: Observations, clinical record for the resident, interview with the resident, two direct care staff and ADOC #105.

[000685]