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
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Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1501-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Tri-County Mennonite Homes
Long Term Care Home and City: Nithview Home, New Hamburg

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.04.02 11:07:58 -04'00'

Additional Inspector(s) Dianne Tone (000686)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11 - 15 and 18 - 21, 2024

The following intake(s) were inspected:

- Intake: #00109856 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Action

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)
Resident and Family/Caregiver Experience Survey
s. 43 (3) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

The licensee did not make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

Review of the 2022-2023 interim Continuous Quality Improvement (CQI) report posted to the home's website did not include documentation of any actions related to concerns identified from the Residents or Family surveys.

The ED acknowledged that the home had not acted on the results of the Residents' and Family surveys to improve the long-term care home and the care, services, programs and goods as part of their CQI actions.

Failure to make every reasonable effort to act on the results of the Residents and Family survey misses an opportunity to work collaboratively to implement care, services or improvements that would enhance their satisfaction with operations of the home.

Sources: Residents and Family survey, interview with ED.
[659]

WRITTEN NOTIFICATION: Advice

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee failed to include the advice of the Family Council in carrying out the satisfaction survey, or of either Council in acting on its results.

Review of Resident Council minutes for 2023 did not show advice of the council was sought in acting on the results of the survey.

The ED stated that they did not seek the advice of the Family Council related to carrying out the survey and that they had not followed up to seek the input of either

Council related to acting on the results of the survey.

Sources: Resident Council minutes, interviews with ED
[659]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee failed to ensure that actions taken related to improving the care, services, programs and goods were based on the results of the satisfaction survey.

The home was unable to provide a documentation related to actions implemented as a result of the satisfaction survey.

The Quality lead stated the CQI actions taken were related the home's priorities for becoming a Best Practice Spotlight Organization (BPSO) as opposed to as a result of the satisfaction survey.

Sources: Interview with Quality lead, interim CQI report
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WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The Licensee failed to ensure that staff cleaned and disinfected shared equipment between resident use in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On a specified date, a PSW did not clean shared equipment after use with a resident.

On another specified date, a PSW stated they cleaned shared equipment with the alcohol based hand rub (ABHR).

Policy #: VII-H10.50, Equipment Cleaning-Resident Care & Medical Equipment provides direction as follows for cleaning lifts which included use of a hospital grade disinfectant between each resident. The manufacturer's recommended disinfectant for tub also included use a hospital grade disinfectant (ED, 1492, Virox, etc.) in a squirt bottle or supplied disinfectant wipes with a cloth or paper towel.

The IPAC lead stated shared equipment was to be cleaned with a specified wipe to prevent the transmission of microorganisms between residents.

Sources: Interviews with PSWs, IPAC Lead, a resident, Observations, LTC policy
[000686]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

IPAC standard #9.1 related to Additional Requirement under the standard directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices would include the proper use of PPE (including appropriate selection, application, removal, and disposal).

A PSW failed to don PPE when entering a resident's room and providing care despite signs posted which indicated additional precautions were required.

An ADOC said staff should know what to do when they see signage posted by a

resident's door and at a minimum, follow the directions of the signage for what PPE to use and for donning and doffing instructions.

When the PSW failed to don PPE when entering the resident's room there was a risk of transmitting infectious organisms to other residents.

Sources: Observations, Isolation and ARO report, interviews with a PSW and a ADOC [000686]

WRITTEN NOTIFICATION: infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The home was unable to provide documentation to show that a review of the monthly surveillance was completed to detect trends from the information collected under O. Reg. 246/22 s. 102 (9).

The Executive Director said that that they do not have documented analysis trending and recognize this was a gap.

Failure to review and analyze the information collected under subsection (9) a minimum of monthly may prevent the home's ability to identify and respond to trends in a timely fashion to reduce the incidence of further infection and outbreaks.

Sources: Q4 Professional Advisory Committee report, surveillance data, interviews with ED and NP
[000686]

WRITTEN NOTIFICATION: Continuous Quality Improvement initiative report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report was prepared on the continuous quality improvement (CQI) initiative for the home for the fiscal year no later than three months after the end of the fiscal year, and, subject to section 271, shall publish a copy of each report on its website.

A 2022/2023 interim quality improvement report was posted on the home's website, however, a 2023 CQI initiative report was not posted for the fiscal year ending on March 31, 2023.

The ED/CQI Committee Lead stated that a 2023 CQI initiative report was not prepared by the home.

Failure to prepare a CQI initiative report is a missed opportunity to track and share the home's progress with residents and their families and staff, related to all actions taken to improve the long-term care home, and the care, services, programs, goods and outcomes from year to year.

Sources: Home's website; interview with ED
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