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: May 6, 2024	
Inspection Number: 2024-1501-0003	
Inspection Type: Complaint	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Nithview Home, New Hamburg	
Lead Inspector Yami Salam (000688)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 26, 30, 2024

The following intake(s) were inspected:

- Intake: #00108799 – Related to resident care

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

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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 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff who provided direct care to a resident were kept aware of the resident's plan of care.

Rational and summary:
A resident's plan of care indicated they were to receive modified care due to an injury. Weeks later, when the resident was deemed safe to resume their regular care, the staff were not made aware of this change. As a result, the resident did not receive their preferred choice of care.

By not ensuring staff were kept aware of the changes to the resident's plan of care, the resident was unable to receive their preferred choice care after they were reassessed.

Source: Review of resident's medical records, interview with complainant, PSW #103, #108 and #109, ADOC #112, Physiotherapist and other staff. [000688]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 has failed to ensure that the Infection Prevention and Control (IPAC) standard issued by the Director was followed by staff.

The IPAC standard for Long-Term Care Homes, revised September 2023, section 10.4 h) and i), stated the home's hand hygiene program shall support residents to perform hand hygiene prior to receiving meals. As well, it said the program shall support residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Rationale and Summary
During an observation of a dining service, multiple residents were not offered hand hygiene before their meal.

Multiple staff members acknowledged that support was not provided to the residents.

IPAC lead stated that staff were expected to offer hand hygiene for the residents prior to their meal.

By not performing hand hygiene, there was an increased risk of disease

transmission among the residents and staff.

Sources: Meal service observation, Hand Hygiene Policy# 1X-G10.10. Reviewed date: January 08, 2024, Interviews with PSW #103, #104, staff #105, IPAC lead and other staff. [000688]