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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: August 22, 2024
Inspection Number: 2024-1501-0004
Inspection Type: Complaint Critical Incident
Licensee: Tri-County Mennonite Homes
Long Term Care Home and City: Nithview Home, New Hamburq

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 30, 31, 2024 and August 1, 2, 6-9, and 14, 2024

The following intakes were inspected:

- Intake #00115755 regarding improper care of a resident
- Intake #00118255 regarding resident neglect
- Intake #00119325 and intake# 120043 regarding a resident's fall's prevention and management.
- Intake #00115979 regarding an enteric outbreak.
- Intake #00116191 regarding concerns about the home's continence care program.
- Intake #00120954 regarding concerns related to the home's resident care and support services.

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

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Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident was provided the proper care consistent with their needs.

Rationale and Summary
A resident rang their call bell because they had to use the washroom. It took staff over 21minutes to respond to the resident's call bell.

The delay in response resulted in an incident which left the the resident feeling emotionally upset and affecting their dignity.

Sources: interviews with a PSW, an ADOC and the DOC, and record review of a resident's clinical records and the home's investigation notes.1705769]

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)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The licensee has failed to ensure that a resident had all their fall interventions in place as specified in their plan at the time of a fall.

Rationale and Summary
The resident fell and sustained injuries as a result of the fall.

Resident Support Aide (RSA), a Registered Nurse (RN), and an Assistant Director of Care (ADOC) said the resident fell from their mobility aide because a fall prevention intervention was not in place. The resident's plan of care stated that the resident was to have the fall prevention intervention when in their mobility aide.

By failing to ensure the resident had all their fall interventions in place as per their care plan, the resident had a fall and sustained injuries.

Sources: interviews with an RSA, an RN, an ADOC, and record review of a resident's clinical records.[705769]

B) The licensee has failed to ensure that a resident had all their fall interventions in place as specified in their plan at the time of their fall.

Rationale and Summary
A resident fell resulting in an injury.

During the fall, the resident's falls prevention equipment was not in place as per the direction in their plan of care.

By failing to ensure the resident had all their fall interventions in place as per their care plan, the resident was at increased risk of injury from their fall.

Sources: interviews with an RN and an ADOC, and record review of a resident's clinical records.[705769]

WRITTEN NOTIFICATION: Communication and Response System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(b) is on at all times;

The Licensee has failed to ensure the home was equipped with a resident-staff communication and response system that was on at all times.

Rationale and Summary
The home's call bell system malfunctioned and caused a delay in a resident's care.

A resident said they required assistance from staff for care. The resident said they needed assistance to go to the toilet but it took staff a while to respond to their call bell.

The home's policy said call bells will be responded to promptly following its initiation.
Call bells on a home area will ring through to all Personal Support Worker's and RPN phones on the home area as well as the RN Charge Nurse's phone. The call bell would send a ring to the PSWs phones, after three minutes the call will ring through to the RPN of the home area, and after another three minutes the call will

go to the RN in charge's phone, as per the call bell fan out system.

According to the home's investigation records and staff interviews, the resident waited 30 minutes to receive care due to a malfunction in the call bell system where some of the staff stated their phone was either delayed in ringing or did not ring at all.

An ADOC said that the phones relied on wifi connection and from time to time the wifi connection would cut out, and when that happened, call bell notifications may not ring on the staff's phones.

Failure of the call bell system may have caused the resident discomfort due to a delay in their care.

Sources: A CIS report, a resident's clinical records, the home's investigation records, and interviews with a resident and staff. 1606]