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:** November 19, 2024

**Inspection Number:** 2024-1501-0005

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Tri-County Mennonite Homes

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

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22-25, 28-November 1, 2024 & November 4, 2024

The following intake(s) were inspected:

- Intake: #00123321 - IL-0129677-CW - complainant regarding fall prevention and management
- Intake: #00124332 - 3004-000029-24 - regarding an injury from unknown cause
- Intake: #00124846 - IL-0130319-AH/ 3004-000032-24 - regarding alleged neglect
- Intake: #00125068 - 3004-000040-24 regarding a fall
- Intake: #00125948 - IL-0130824-CW Complainant regarding falls and skin and wound concerns.

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

Skin and Wound Prevention and Management
Infection Prevention and Control

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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) 18.**
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure that eleven residents were afforded privacy in treatment and in caring for their personal needs.

**Rationale and Summary**
A personal Support Worker (PSW) took pictures of ten residents over a several week period on their personal cell phone. Another PSW took pictures of a resident on their personal cell phone.

The Executive director stated that both PSW's violated the LTCH's policy by taking these pictures of residents on their personal cell phones.

Multiple resident's privacy were at risk when the PSW's took pictures of them on their personal cell phones.

**Sources**: investigation notes for Critical incidents, interviews with PSW's and other staff

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

**Rationale and Summary**
Two PSW's reportedly told the registered staff about potential neglect of residents by prior shifts.

A registered nurse stated the PSWs had previously brought forward complaints of missed care, however, the Registered Nurse (RN) took the allegations as complaints and did not report them.

The Executive Director (ED) stated there were a lot of PSW complainants regarding other shifts and that may have normalized the concerns that led to registered staff not investigating and reporting potential neglect.

Multiple residents were at risk of delayed assessment and potential interventions

when allegations of neglect were not immediately reported to the director.

**Sources**: Critical incidents, clinical record of residents, interviews with PSWs and other staff.

## WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their strategies to reduce or mitigate falls for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there were strategies to reduce or mitigate falls and that they were complied with.

**Rationale and Summary**
In an eight-month period a resident had multiple falls from different surfaces.

The resident's Substitute Decision Maker (SDM) requested additional fall prevention interventions but these were not implemented for multiple months, in response to the resident sustaining significant inquires from their falls.

The Restorative Care Aide acknowledged that not implementing all the fall prevention interventions was an over-sight.

Failure to implement the fall prevention interventions in the resident's plan of care decreased the home's ability to reduce or mitigate falls and injury from falls for the resident.

**Sources**: Observations, resident's clinical record, Fall Prevention Policy, interviews with the Restorative Care Lead and other staff

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

**Rationale and Summary**
A resident had several falls in a two day period which resulted in injuries. A few days after their fall, they developed an additional injury.

Staff were required to initiate a weekly assessment with a detailed progress note for this injury.

Registered staff acknowledged that an initial skin and wound assessment should have been completed on the resident's injuries when they were initially identified and re-evaluated if there was a significant change.

Staff did not initiate clinical skin assessments for a resident when new altered skin integrity was identified. This made it difficult to determine which fall caused the residents' injuries, and to track the progression of the injuries.

**Sources**: resident clinical record, interviews with RN and other staff.

## WRITTEN NOTIFICATION: Infection prevention and control program

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).

In accordance with the IPAC Standard, revised September 2023, section 7.3 (b), the IPAC Lead shall ensure that audits are performed as required.

Specifically, the licensee has failed to ensure that the IPAC Lead had implemented audits, at least quarterly, to confirm that all staff could perform the IPAC skills required of their role.

**Rationale and Summary**

The IPAC Lead provided the Inspector with the home's IPAC audits from July to October 2024. There was no documentation related to auditing to ensure that all staff can perform IPAC skills required of their role, or of auditing of the nightshifts.

The IPAC Lead stated that they audited registered and PSW staff and they were not aware of any audits related to specific skills of all staff, for example recreation staff versus direct care staff.

When the LTCH failed to complete quarterly audits of role specific IPAC skills, the home was unaware if the IPAC practices being implemented by all staff.

**Sources**: Interview with the IPAC Lead and other staff, Hand Hygiene and PPE audits.