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

Public Report

Report Issue Date: May 9, 2025

Inspection Number: 2025-1501-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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): April 24-25, 28-30, and May 1-2, and 5- 8, 2025

The following intake(s) were inspected:

- Intake: #00141321 - Neglect of resident by staff
- Intake: #00141419 - Complainant regarding resident care
- Intake: #00141701 - Follow-up #: 1 related to Administration of drugs
- Intake: #00144438 - complainant concerns regarding supply of incontinence products
- Intake: #00145946 - Physical abuse of resident by staff

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1501-0002 related to O. Reg. 246/22, s. 140 (2)

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

Continence Care
Skin and Wound Prevention and Management
Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 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 when a resident exhibited altered skin integrity, a clinically appropriate skin and wound assessment was completed.

Sources: Progress Notes, Electronic Treatment Administration Record (eTAR), PCC skin application, interviews with staff

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Ensure all registered staff and nursing managers are re educated on policies and procedures related to Intravenous (IV) and Peripherally Inserted Central Catheters (PICC) lines

2. Review and revise the home's policy and procedures related to the admission/readmission processes and re-educate registered staff and personal support workers (PSWs) on these processes as they relate to their role:
a) expectations related to timely, comprehensive assessments of residents
b) communication of new orders to staff and
c) any changes in direction related to the provision of care.

3. Maintain a record of the following:
-Contents of the education provided
-Date(s) and time(s) the education was held
-Who provided the education
-The names of the staff that completed the training

4. Develop and implement a written plan to include ongoing auditing of resident records to ensure accuracy, comprehensiveness and completion of Head-to-Toe

assessments, weekly skin assessments for all altered skin integrity, TARs, care plans, and appropriate referrals. The plan should include but not be limited to:
a) The staff member responsible for conducting/overseeing the audits
b) Audits should include new admission and re-admission records as well as the set number of audits that will be conducted on each unit each month of other resident records
c) Identification of any deficiencies
d) Corrective action implemented and documented
e) The date of the corrective action documented
The records of auditing should be maintained onsite at the home.

5. Conduct audits of the admission/ readmission process, including but not limited to the process of readmission and documentation. Complete four monthly audits of each home area for a period of three months from the time the report is issued, to ensure that admission / re-admission processes and policies are followed.

6. Maintain a written record of the completed audits, including but not limited to: date and time audits were conducted, resident name, staff name(s), and any corrective action taken in response to the audit.

Grounds

The licensee failed to protect resident #001 from neglect.

In accordance with O. Reg. 246/22 s. 7, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was readmitted to the home on an identified date and following their readmission, there were no documentation, or assessments competed for any of the

identified areas of altered skin integrity. The treatment record was not updated to include ongoing monitoring. The medication reconciliation was not completed, and the physician was not notified.

On the following day shift, none of the readmission orders were followed and the residents' altered skin assessment was not comprehensive by the registered staff.

In addition, the home's policy directed staff that an identified procedure could only be performed by by a specified staff member. The policy was not followed and no physician's order was obtained.

Another identified registered nursing staff also did not complete a weekly assessment on the altered skin integrity and documented incorrectly on the treatment record.

The skin and wound assessment revealed that there was no weekly assessment of two of the surgical wounds completed.

Failure to follow physicians' orders, and the lack of communication and assessments, placed the resident's health, safety, and well-being at significant risk of harm.

Sources: Policy IV and PICC Line review date January 2025, clinical record review, Discharge Summary record from Sunnybrook, Discharge summary record from St Mary's hospital, Skin and wound assessment, Head to toe assessment, treatment record for January/February, progress notes, Point of Care review, interview with registered staff, PSW and the DOC.

This order must be complied with by July 10, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

History:
2025-1501-0001 issued date 2025-01-23- WN

2023-1501-0005- issued dated 2023-09-29-Compliance Order
2023-1501-0004—issued date -2023-06-26-WN
2023-1501-0002-issued date_ 2023-01-12-WN

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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609 Kumpf Drive, Suite 105
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.