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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# Public Report

**Report Issue Date:** July 18, 2025

**Inspection Number:** 2025-1501-0004

**Inspection Type:**
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): July 10 - 11, 14 - 18, 2025

The following intake(s) were inspected:

- Intake: #00147049 - Follow-up - CO #001/2025-1501-0003, FLTCA, 2021 - s. 24 (1) Duty to Protect. CDD July 10, 2025
- Intake: #00147212 - Resident Care and Support Services
- Intake: #00148144, 00148242 - Prevention of Abuse and Neglect and Responsive Behaviours
- Intake: #00148987 - Prevention of Abuse and Neglect and Reporting and Complaints
- Intake: #00150344 - Prevention of Abuse and Neglect

## Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1501-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee failed to ensure that a resident was protected from physical abuse and neglect.

A) As per O. Reg. 246/22, s. 2 (1) (c), "physical abuse" is defined as the use of physical force by a resident that causes physical injury to another resident.

A resident had an item, which they used to cause injury to another resident.

**Sources:** Resident clinical records, Critical Incident Report and staff interviews.

B) As per Ontario Regulation 246/22, s. 7, "neglect" is defined as 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 not provided their required personal care for the duration of a shift resulting in increased responsive behaviours and skin changes.

**Sources**: Critical incident report, home's investigation notes, Policy: Prevention of Abuse and Neglect of a Resident (VII-G-10.00), resident progress notes, documentation survey report, assessments, and staff interviews.

## 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 ensure an allegation of neglect to multiple residents by staff was immediately reported to the Director.

An incident reported by Personal Support Worker (PSW) staff alleged that potential or suspected neglect of multiple residents occurred. The home did not report the

incident to the Director until one day after the incident.

**Sources**: After Hours Report, Critical Incident report, Policy: Prevention of Abuse and Neglect (VII-G-10.00), and staff interviews.

## WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (2)**
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that actions taken for multiple residents as it related to personal care, including assessments, reassessments, interventions and responses to interventions were documented.

Two staff members were responsible for the care of several residents. One staff member documented providing care for all the residents prior to providing the care. The Director of Care (DOC) stated that the expectation of staff is that documentation is done after the tasks are completed, and that each PSW is responsible for documenting under the residents they are responsible for.

**Sources**: Policy: Documentation (VII-J-10.00), Resident documentation survey reports, and staff interviews.

## WRITTEN NOTIFICATION: Behaviours and Altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 60 (a)**

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that the responsive behaviour intervention outlined in a resident's plan of care was in place. It was noted by the home that the intervention was not in place after an incident with two residents that resulted in an injury. During the inspection it was observed by the inspector that the intervention was not in place on multiple occasions.

**Source:** Critical Incident report, resident clinical records, observations, and staff interviews.