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: September 19, 2025
Inspection Number: 2025-1501-0005
Inspection Type: 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): September 9 - 12 and 15 - 19, 2025

The following intake(s) were inspected:

- Intake: #00154414 /3004-000034-25: Alleged resident to resident abuse
- Intake: #00155103 /3004-000036-25: Resident fall with injury
- Intake: #00157703 /3004-000042-25: Alleged resident to resident abuse

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

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 (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.

The licensee failed to ensure staff followed a resident's plan of care, when staff did not engage the deterrent across the doorframe.

Sources: Observations, care plan, interview with residents and staff

WRITTEN NOTIFICATION: Duty to protect

NC #002 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 home failed to protect a resident from abuse by a co-resident when the co-resident expressed both verbal and physical responsive behaviours towards the resident.

Sources: Critical incident 3004-000042-25, progress note, interviews with resident, ED and staff

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 an allegation of abuse of a resident to the Director. The alleged incidents were reported three months later.

Sources: progress notes, interviews with staff and resident

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques with a resident, when they had not followed the direction of the physiotherapist's assessment for the type of transfer to complete.

Sources: progress notes, physiotherapy assessment, interviews with staff and physiotherapist

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 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 failed to implement their policy for falls prevention following a resident's fall.

In accordance with s. 11(1) b, the home's policy related to falls documented that the resident should not have been moved when an injury was suspected.

Staff moved the resident despite the resident's complaint of pain and having facial grimacing, and later tried to have the resident weight bear. The resident was sent to hospital and diagnosed with an injury.

Sources: Falls prevention policy, VII-G010.30, reviewed Sept.2024 interviews with DOC and staff

WRITTEN NOTIFICATION: Altercations and other interactions

between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that staff implemented interventions identified to minimize the risk of altercations or potentially harmful interactions involving a resident which resulted in a harmful interaction between the resident and a co-resident.

Sources: Critical incident #3004-000034-25, progress notes, care plan

WRITTEN NOTIFICATION: Requirements related to restraining by a physical device

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 3.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

The licensee failed to ensure that hourly monitoring was completed when a restraint was used for a resident.

Sources: Restraint monitoring record, Memo to staff re: restraint documentation, Restraint implementation protocols, last revision - November 2015, VII - E- 10.00, interview with staff