Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2013	2013_226192_0019	L-000760-13	Critical Incident System

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St., New Hamburg, ON, N3A-2K4

Long-Term Care Home/Foyer de soins de longue durée

NITHVIEW HOME
200 Boullee Street, New Hamburg, ON, N3A-2K4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEBORA SAVILLE (192), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 13, 2013

This inspection was conducted concurrently with Critical Incident L-000817-13

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Assistant Director of Care, Registered Practical Nurses, and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed medical records, Policy and Procedures, incident investigation notes, and the list of medications supplied in the emergency drug box.

The following Inspection Protocols were used during this inspection:
Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #001 was readmitted to the home in September 2013. The needs of resident #001 were not addressed by staff of the home.

Resident #001 complained of pain that was not addressed. When put to bed the resident called out frequently requesting attention from staff. Staff responding documented that they had told the resident to stop calling out as they were disruptive for others.

The resident made multiple requests to be pulled further up in the bed, this request was denied. At 2100 resident #001 was no longer calling out, staff indicated that the resident was resting quietly in their bed. At 2130 resident #001 was noted to be absent from their bed and was found on the floor, vital signs absent. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the following resident's right is respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

The home's policy Admission of a Resident (Routine), effective May 2008 indicates that on admission the Registered Nurse shall complete a nursing history, and assessment considering the resident's physical, mental, and emotional condition.

The Re-Admission Checklist indicates that the Registered Practical Nurse is to do skin and pain assessments.

Resident #001 was readmitted to the home in September 2013 from hospital. Documentation indicates that following admission the resident was frequently calling out, making frequent requests of staff, complaining of discomfort in the right hip, and requesting staff to sit with them and hold their hand.

The resident was assisted to bed related to pain in their right hip. Interview and record review confirm that no pain assessment was completed.

There is no documentation of assessment of the residents mental and emotional status at the time of readmission.

Resident #001 had a history of falls from bed. In August 2013 resident #001 was found on the floor in their room. No fall assessment was completed at the time of readmission to the home despite the known risk for resident #001.

In September 2013 resident #001 was found on the floor, vital signs absent.

The home's policy related to Admission and readmission of a resident was not followed when resident #001 was readmitted from hospital in September 2013. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee ensures that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

Issued on this 3rd day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Debora Saurillo (192)