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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2015	2015_271532_0025	024896-15	Resident Quality Inspection

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

NUZHAT UDDIN (532), CHAD CAMPS (609), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21, 22, 23 and 28, 2015

Concurrent inspections were completed: 012409-15, 014697-15,004169-15,019180-15

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Director of Support Services, Director of Recreation and Volunteer Services, Infection Prevention and Control Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary aide, Recreation Care Aide, Housekeeping and Maintenance staff , Family and Resident Council Representatives.

Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified staff member was heard using inappropriate language and unprofessional behaviour towards an identified resident.

Upon interview with the ED and DOC, it was stated that the identified staff member had been overheard on a separate occasion using inappropriate language towards another identified resident. (519)

B) A record review revealed that there was a complaint alleging that the same identified staff member had not provided continence care to the identified residents.

All of the identified residents were saturated. Record review and the DOC indicated that this was not typical of the identified residents.

Internal investigation notes stated that the alleged staff member had confirmed that the care related to continence was not provided as it was difficult to get the identified residents back to sleep.

This was not in accordance with the resident's plan of care.

Review of the flow sheets with the Director of Care (DOC) indicated that the care charted was not provided by the identified staff member.

Record review further revealed that the alleged staff member had no training for this calendar year, even though there were care related issues related to the identified staff member.

The license has failed to ensure that the residents were protected from abuse and neglect when the staff member continued to engage in resident neglect, verbal abuse and unprofessional behaviour. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A) During a documentation review it was identified that a specified Resident was incontinent of bladder.

The care plan for the identified resident was reviewed and it stated under bladder function that the resident was usually continent.

Upon interview with the Director of Care (DOC), it was confirmed that it was the home's expectation that the plan of care would be updated with the results of the MDS assessment done quarterly. (519)

B) Observations of the identified Residents revealed the use of an assistive device.

A review of the plans of care for the identified residents did not give clear direction regarding the assistive device.

An interview with the registered staff confirmed that the care set out in the plan of care was not clear related to the assistive device.

An interview with the ED confirmed that it was the home's expectation that the plan of care set out clear direction to the staff and others who provide direct care to residents and that the care set out in the plan of care related to the assistive device for the identified residents did not give clear direction. [s. 6. (1) (c)]

2. The Licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Record review and skin assessment for an identified Resident indicated altered skin integrity.

Plan of care provided directions and specific interventions for the staff to follow.

Observations revealed that the interventions outlined in the plan of care were not implemented.

Restorative Care Registered Practical Nurse confirmed the above observations and confirmed that the care was not provided as per resident's plan of care.(532)

B) Observations of the bed of an identified Resident revealed an assistive device was being used.

A review of the plan of care for the identified resident revealed specified interventions related to the assistive device.

An interview with registered staff confirmed that the care set out in the plan of care was

not being provided related to the type and position of the assistive device .

An interview with the Executive Director (ED) confirmed that it was the home's expectation that the care provided to the resident was as specified in the plan of care and this did not occur and should have. [s. 6. (7)]

3. The Licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A review of the clinical record for the identified Resident revealed no documentation that care was performed with the resident as specified in the plan of care.

An interview with registered staff revealed that the care for the residents was being provided in the home and that this care was not documented anywhere in the clinical record.

An interview with the DOC confirmed that it was the home's expectation that all care of residents was to be documented and it was not. [s. 6. (9) 1.]

4. The Licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Observations of an identified Resident revealed that the resident had one of their assistive devices in place and not the other.

An interview with Personal Support staff revealed that the assistive device had not been used with the resident for a while.

A review of the plan of care for the resident indicated staff were to verify that the assistive device was in place.

An interview with the registered staff confirmed that it was the home's expectation that the plan of care was to be revised when the resident's care needs changed, and when the oral care needs of the resident had changed, the plan of care was not revised and should have been. [s. 6. (10) (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 to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care provided to the resident is as specified in the plan, to ensure that the provision of the care set out in the plan of care is documented, to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Record review for identified Residents indicated that they required an assistive device at all times.

Observations made with Restorative Care Registered Practical Nurse (RPN) confirmed that all three residents used an assistive device .

In an interview the Restorative Care RPN shared that she completed an MDS assessment called MDS Bedside Full Assessment tool to determine the reason why the assistive device was needed and this was completed quarterly.

B) During Stage One observations of the Resident Quality Inspection (RQI) it was noted that an identified Resident had an assistive device in place.

The Restorative Care Registered Practical Nurse (RPN) reported that the MDS Bedside Assessment Tool and Quarterly Care Plan Review were the documents used to inquire if a resident required an assistive device and for what reason. The RPN was not familiar with the document provided to the Inspector by the Director of Care (DOC) titled, "Nithview Home Assessment of Resident for Restraint or Personal Assistance Device (PASD)".

The DOC reported that the MDS Bedside Full Assessment Tool was a working copy for staff and not an assessment for the assistive device and confirmed that the expectation of the home was to have the Nithview home assessment completed before any physical mechanical environment restraint or a PASD was used. The DOC confirmed that the assessment was not completed for any of the above residents. [s. 15. (1) (a)]

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 to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering and any identified responsive behaviours.

An identified Resident was observed dressed in night clothes during the day shift.

A review of the clinical record revealed thirty-five episodes of refusing care, meals or activities.

An interview with Behaviour Support of Ontario (BSO) staff confirmed that over the last month the resident had been identified as having increased episodes of refusing care.

A review of the plan of care for the resident revealed no identification of responsive behaviours or interventions to address the resident's responsive behaviour.

An interview with the DOC confirmed that it was the home's expectation that the responsive behaviour plan of care should include any mood and behaviour patterns and responsive behaviours and in the case of the increased responsive behaviours of the resident this did not occur. [s. 26. (3) 5.]

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 to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering and any identified responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Record review for s specified resident stated that the resident had altered skin integrity on a number of identified dates.

In an interview the specified resident was not able to confirm if they had skin issues at this time.

Record review revealed that there was no skin assessment completed by a registered staff and this was confirmed by the DOC.

B) Clinical record review stated that the identified Resident had altered skin integrity.

Observation revealed that the resident had altered skin integrity.

Record review revealed that there was no skin assessment completed by a registered staff.

The DOC confirmed that there should have been a skin and wound assessment called Skin and Wound Assessment completed at the time when the altered skin integrity was noted. The DOC confirmed that there was no skin assessment completed by a registered nursing staff, she reported that the staff do complete the electronic Treatment Administration Record (TAR), however, the expectation was for the registered staff to complete an assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Record review and Resident Assessment Protocol (RAP), revealed that the identified resident had altered skin integrity.

Record review revealed further altered skin integrity on different identified dates.

Record review and the plan of care stated a pressure relieving device was in place.

Observation were made with the Restorative Care RPN and it was noted that the identified resident did not have interventions as stated in the plan care.

The Director of Care in an interview confirmed that there was no pressure relieving device as stated in the plan of care.

The Restorative Care RPN asked the resident if they preferred to have a pressure relieving device and the resident stated they would.

It was confirmed with the Restorative Care RPN that the resident exhibiting altered skin integrity should have received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection however, they did not. [s. 50. (2) (b) (ii)]

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 to ensure that when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment,to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A) A review of the most recent RAI-MDS for an identified Resident revealed a change in the level of incontinence.

A review of the home's Continence Care Assessment completed for the resident revealed the assessment did not address potential restore function with specific interventions.

An interview with the DOC confirmed that it was the home's expectation that the Continence Care Assessment should address potential continence to restore function with specific interventions, that the current assessment did not address potential to restore function and should have.

A review of the home's policy on continence assessment revealed that the residents that were incontinent were reassessed at least quarterly and as their condition changes.

The DOC confirmed that the quarterly continence reassessment instrument was the continence section of the RAI-MDS. The DOC confirmed that the continence section of the RAI-MDS did not address causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that the continence section of the RAI-MDS was not a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The DOC confirmed that it was the home's expectation that the continence assessment should address causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that the quarterly continence assessment did not address the cited components and should have. The DOC also confirmed the current continence assessment was not a clinically appropriate assessment instrument specifically designed for the assessment of incontinence and should be.(609)

B) During a documentation review it was noted that an identified Resident had a continence care assessment completed on admission.

Record review and the Minimum Data Set (MDS) revealed that the identified Resident had a change in the level of incontinence.

Record review stated that there was not an updated continence care assessment completed for the change in continence.

Upon interview with a Registered Nurse and Registered Practical Nurse, it was confirmed that a full Continence Care Assessment was only completed on residents upon

admission to the home. Quarterly, it was discussed among the staff if the resident's level of continence had deteriorated and then the care plan would be updated.

The DOC confirmed that it was the home's expectation that when there was a change in the resident's level of continence noted in the quarterly MDS that a full Continence Care Assessment would be done, to determine the need and to update the resident's plan of care. [s. 51. (2) (a)]

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 to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The Licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Observations during the initial tour of the home revealed an unlocked and unattended utility room door on the first floor nursing area of the home. On the shelf on the utility room, disinfectant, hazardous substances were identified.

An interview with the ED confirmed that it was the expectation of the home that all hazardous substances at the home were to be kept inaccessible to residents at all times and in the case of the hazardous chemicals housed in the utility room this did not occur and should have. [s. 91.]

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 to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention: annually or as determined by the licensee, based on the assessed training needs of the individual staff member.

An identified staff was heard using inappropriate language and unprofessional behaviour towards the resident

It was confirmed by the ED and DOC that the identified staff member has not had retraining in 2015.

The DOC confirmed that the staff member was booked to attend the training [s. 221. (2)]

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 to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention: annually or as determined by the licensee, based on the assessed training needs of the individual staff member, to be implemented voluntarily.

WN #9: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During Stage One observations of the Resident Quality Inspection (RQI), it was noted that an identified Resident had an assistive device in place.

The documentation review revealed that the assistive device was mentioned in the care plan, the Quarterly Care Plan Review, and the MDS Bedside Assessment Tool as being necessary for the identified Resident.

Upon review of the home's policy on least restraint, it was noted that when it was determined that an assistive device was to be used, an informed consent was to be obtained.

Upon interview with the Restorative Care Registered Practical Nurse, it was stated that the Registered Staff have never obtained consent for an assistive device.

Upon interview with the Director of Care, it was confirmed that a consent was not obtained for the assistive device and the policy was not complied with. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked.

Observations revealed identified residents performing exercises in the Chapel off the home's main lobby. These residents were left unsupervised and unattended for up to five minutes while staff brought residents back to their home areas.

Observations of the hallway across from the Chapel revealed an unlocked and unattended door leading to a stairwell to the home's retirement home area.

An interview with the home's Receptionist confirmed that residents have been known to ambulate down the hall past the unlocked and unattended stairwell door leading to the retirement area of the home.

An interview with Recreation staff confirmed that residents were left unattended in the Chapel when staff were escorting other residents to and from the exercise class and there were instances where residents would leave the Chapel and ambulate down the hallway past the unlocked and unattended door leading to the stairwell to the retirement area of the home.

An interview with the ED confirmed that it was the home's expectation that all doors leading to stairways were to be kept closed and locked and in the case of the unlocked and unattended door leading to the stairway down to the retirement area of the home across from the Chapel, this did not occur and should have. [s. 9. (1) 1. i.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical Incident System (CIS) report was completed regarding improper treatment of a resident.

The CIS report was not amended with the results, however, the investigation was completed.

The DOC confirmed that the CIS was not updated to ensure the results of the neglect investigation were reported. [s. 23. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In an interview the DOC confirmed that there was no annual evaluation of the skin and wound care program, that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home's staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's staffing and back-up plan revealed no annual evaluation of the staffing plan for the 2014, calendar year.

An interview with the DOC confirmed that it was the home's expectation that the staffing plan was to be evaluated annually, that the staffing plan was not evaluated for the 2014, calendar year and should have been. [s. 31. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During the dining observation it was observed that an identified staff member had scraped dirty dishes and then proceeded to stand beside a resident and feed the resident. The staff member was also observed to move from resident to resident feeding only a spoonful at one time.

Upon interview with the Director of Care it was confirmed that it was the home's expectation that the direct care staff sit down to feed residents using the proper technique, so to prevent choking risk for the resident. She also confirmed that was not the home's practice to go from resident to resident feeding one spoonful at a time. [s. 73. (1) 10.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Upon interview with the DOC it was stated that all of the mandatory program evaluations were completed in the fall of each year.

The DOC confirmed that she had not completed an Abuse and Neglect annual program evaluation since April 2014, when she began as the DOC. [s. 99. (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During an interview with the Assistant Director of Care (ADOC), it was stated that she logged the trends of infections in the home and then passed this along to the Director of Care (DOC). The ADOC stated it was the DOC who completed the Annual Evaluation of the Infection Prevention and Control (IPAC) program.

Upon interview with the DOC it was confirmed that the annual IPAC evaluation has not yet been completed for the year 2015.

The DOC also confirmed that the annual IPAC evaluation for 2014 was not done and the discussion of this was on the agenda for the next Professional Advisory Committee (PAC) meeting. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the dining observation on September 14, 2015, at 1218 hours, it was observed that there was a PSW scraping dirty dishes, then attempting to feed a resident, then scraping dirty dishes, then proceeding to serve coffee and tea, all without practicing hand hygiene.

This PSW was observed again at 1232 hours to be clearing dirty dishes and then immediately went and sat down to feed a resident, all without practicing hand hygiene.

Upon interview with the Director of Care on September 14, 2015, at 1235 hours, it was confirmed that it was the home's expectation that all staff practice hand hygiene between handling dirty dishes and feeding or serving food to a resident. [s. 229. (4)]

Issued on this 13th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), CHAD CAMPS (609), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2015_271532_0025
Log No. / Registre no:	024896-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 13, 2015
Licensee / Titulaire de permis :	TRI-COUNTY MENNONITE HOMES 200 Boullee St., New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	NITHVIEW HOME 200 Boullee Street, New Hamburg, ON, N3A-2K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Klassen

To TRI-COUNTY MENNONITE HOMES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

a) The Licensee shall assess the individual training needs of the identified staff member and ensure that abuse and resident rights education and training are provided.
b) The licensee shall ensure ongoing evaluation of the training and education of the identified staff member to ensure that the identified residents are protected from verbal abuse and are not neglected related to continence care.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified staff member was heard using inappropriate language and unprofessional behaviour towards an identified resident.

Upon interview with the ED and DOC, it was stated that the identified staff member had been overheard on a separate occasion using inappropriate language towards another identified resident. (519)

B) A record review revealed that there was a complaint alleging that the same identified staff member had not provided continence care to the identified residents.

All of the identified residents were saturated. Record review and the DOC indicated that this was not typical of the identified residents.

Internal investigation notes stated that the alleged staff member had confirmed that the care related to continence was not provided as it was difficult to get the identified residents back to sleep.

This was not in accordance with the resident's plan of care.

Review of the flow sheets with the Director of Care (DOC) indicated that the care charted was not provided by the identified staff member.

Record review further revealed that the alleged staff member had no training for this calendar year, even though there were care related issues related to the identified staff member.

The license has failed to ensure that the residents were protected from abuse and neglect when the staff member continued to engage in resident neglect, verbal abuse and unprofessional behaviour.
(532)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : London Service Area Office