



Ministry of Health and
Long-Term Care

Ministère de la Santé et des Soins
de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de
longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2019	2019_792659_0010	002228-19, 009893-19	Complaint

Licensee/Titulaire de permis

Tri-County Mennonite Homes
200 Boullee Street 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

JANETM EVANS (659), KRISTAL PITTEK (735)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 30 and 31, 2019.

The following intakes were completed as part of this inspection:

Log #002228-19\ IL-63751-CW/IL63855 CW related to resident to resident and resident to staff altercations.

Log #009893-19\ Complaint related to Medication Administration.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Executive Director (ED), former Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument Coordinator (RAI C), Behavioural Support Ontario staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Scheduler, Restorative Care.

Observations were completed related to Medication Administration, resident to resident interactions and resident to staff interactions.

This inspection was completed concurrently with Critical Incident (CI) inspection #2019_792659_0011.

The following Inspection Protocols were used during this inspection:

Medication

Reporting and Complaints

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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 O.Reg 79/10, s. 101. Dealing with complaints



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Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated.

Two complaints were submitted to the Ministry of Health and Long Term Care (MOHLTC) on two specified dates respectively, in relation to multiple concerns regarding resident to resident and resident to staff responsive behaviours.

A progress note on a specified date, documented that a verbal complaint was made to the ADOC related to an identified resident's responsive behaviours.

The licensee's "Complaints Management Program" Policy # XXIII-A-10.40, with a current revision date of August 2016, indicated that any complaint (verbal, written, telephone, email, or text) received at the care community or at the support services office from residents, families, visitors, and team members shall be investigated, and actions shall be taken for resolution.

No documentation of an investigation related to the identified concerns was provided for review.

The ADOC stated that a verbal complaint had been received in relation to the identified resident's responsive behaviours and concern for the safety of a co-resident and others.

The CEO stated that the complaint was not investigated.

The licensee failed to ensure that the verbal complaint made concerning the identified resident's responsive behaviours was investigated. [s. 101. (1) 1.]



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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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident shall be investigated and resolved where possible; where the complaint alleges harm or risk of harm the investigation shall be commence immediately, to be implemented voluntarily.

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.