Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date June 13, 2022
Inspection Number 2022_1501_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Tri-County Mennonite Homes

Long-Term Care Home and City
Nithview, New Hamburg

Lead Inspector
Helene Desabrais #615

Additional Inspector(s)
Josee Snelgrove #674 (In the purpose of shadowing)

Choose an item.

Helene Desabrais
Digitally signed by Helene Desabrais
DN: c=ca, st=on, o=Government of Ontario, ou=People, serialNumber=DSAP372862, cn=Helene Desabrais
Date: 2022.06.13 16:01:16 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30, 31, June 1, 2, 6, 7, 8, and 9, 2022.

The following intake(s) were inspected:

- Intake #003971-22 (CIS) related to falls prevention.
- Intake #005972-22 (Complaint) related to prevention of abuse, neglect, and retaliation.
- Intake #006832-22 (Follow-up) Order #001 related to falls prevention, CDD May 13, 2022.
- Intake #006834-22 (Follow-up) Order #002 related to infection prevention and control, CDD May 03, 2022.
- Intake #006833-22 (Follow-up) Order #001 related to responsive behaviours policy, CDD May 13, 2022.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 8. (1)	2022_923751_0007	001	#615
O. Reg. 79/10	r. 229. (4)	2022_923751_0008	002	#615
O. Reg. 79/10	s. 53(4)(c)	2022_923751_0008	001	#615

Previously Issued Compliance Order(s)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s.29 (3) 11. A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

The licensee has failed to ensure that 22 residents received a Heat Risk Assessment to ensure that protective measures to prevent or mitigate heat related illness were in place.

A review of a resident's plan of care did not include a Heat Risk Assessment and protective measures to prevent or mitigate heat related illness.

The Director of Care (DOC) stated that a Heat Risk Assessment and protective interventions were not completed for 22 residents and should have been completed.

Sources: A resident's clinical records, home's "Hot Weather – Management of Risk" (Last reviewed March 2015), interviews with a Registered Practical Nurse and the DOC.

Date Remedy Implemented: June 1, 2022 [#615]

WRITTEN NOTIFICATION [LEGISLATIVE SECTION TITLE]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.40

The licensee has failed to ensure that staff used safe transferring and positioning devices when assisting a resident.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

A resident was observed in bed with a specific sling size on their wheelchair. There was no signage at the foot of their bed to direct the staff as to what sling size to use for transfers. On a different day, the resident was observed with a sling of a different size in their wheelchair.

It was documented that a Restorative staff had assessed the resident for transfers and indicated to staff to use a specific sling size when transferring the resident.

The resident's care plan indicated that they needed the specific sling size for their transfer.

A Personal Support Worker (PSW) stated that they were using two different sling sizes to transfer the resident. There was usually signage at the foot of their bed to indicate to staff what size was to be used, but in this case there were not.

A Restorative Staff stated they had assessed the resident for a specific sling size and if staff used a different size, there was a risk that the resident could fall. They stated that there should be signage identifying which sling size staff were to use for the residents, and staff should follow the residents' care plan for transfers.

Not using the appropriate sling size for the resident posed a risk of fall during transfers.

Sources: A resident's clinical records, observations of a resident, interviews with a Registered Nurse, a PSW and a Restorative Staff.