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
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Original Public Report

Report Issue Date: January 27, 2023	
Inspection Number: 2023-1501-0002	
Inspection Type: Critical Incident System	
Licensee: Tri-County Mennonite Homes	
Long Term Care Home and City: Nithview Home, New Hamburg	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2023.02.02 14:21:39 -05'00'
Additional Inspector(s) Craig Michie (000690) was present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 4, 5, 6, 9, 10, 11, 12 and 13, 2023.

The following intake(s) were inspected:

- Intake #00001780 (Critical Incident (CIS) 3004-000025-22);
- Intake #00001859 (CIS 3004-000024-22);
- Intake #00002127 (CIS 3004-000030-22);
- Intake #00002502 (CIS 3004-000026-22);
- Intake #00005120 (CIS 3004-000019-22);
- Intake #00005255 (CIS 3004-000014-22);
- Intake #00007155 (CIS 3004-000035-22);
- Intake #00013534 (CIS 3004-000039-22),
- Intake #00014797 (CIS 3004-000043-22), related to prevention of abuse and neglect and, responsive behaviours.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee has failed to ensure that a resident was protected from abuse by another resident.

For the purpose of this Act and Regulation, "physical abuse means the use of physical force by a resident that causes physical injury to another resident."

Summary and Rational

A resident had a history of responsive behaviours since their admission and had interventions in place to help manage those behaviours. The resident's progress notes in Point Click Care (PCC), indicated that the resident's responsive behaviours were increasing, and additional monitoring was added in their interventions.

The home submitted a Critical Incident that indicated video footage was reviewed by the DOC and observed that the resident exhibited responsive behaviours towards another resident causing injury, and the heightened monitoring was not in place.

A PSW stated that safety was a concern given the resident's unpredictable behaviours.

The resident's care plan did not include heightened monitoring until after the incident and there were no interventions to direct the staff what to do when this monitoring was not in place.

The BSO Lead – Assistant Director of Care (ADOC) acknowledged that the heightened monitoring was not in place at the time of the incident.

Sources: Residents' clinical records, home's CIS, interviews with two PSWs, the BSO Lead – ADOC and the Director of Care.

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