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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: January 23, 2025

Inspection Number: 2025-1501-0001

Inspection Type:
Critical Incident

Licensee: Tri-County Mennonite Homes

Long Term Care Home and City: Nithview Home, New Hamburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15, 16, 20-23, 2025

The following intake(s) were inspected:

- Intake: #00131143 regarding an ARI Covid-19 outbreak
- Intake: #00132095 regarding fall of a resident with injury
- Intake: #00133522 regarding alleged neglect of a resident
- Intake: #00134960 regarding alleged improper care of a resident

The following intake(s) were completed:

- Intake: #00134607 regarding a fall of a resident with injury
- Intake: #00134561 regarding a Norovirus outbreak
- Intake: #00135988 regarding an Enteric outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that resident #001 was not neglected by staff.

"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Staff heard a resident crying and found them alone, attached in an assistive device and with no call bell in their proximity. The home's investigation revealed that the resident had been left unattended for approximately 15 minutes by staff.

Sources: Critical Incident report, resident clinical records, and interviews with resident and staff.