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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 2018	2018_418615_0004	001871-18	Resident Quality Inspection

Licensee/Titulaire de permis

Ritz Lutheran Villa
16 Lot Road 164 5# R.R. #5 MITCHELL ON N0K 1N0

Long-Term Care Home/Foyer de soins de longue durée

Ritz Lutheran Villa
4118A Road 164, R.R. #5 MITCHELL ON N0K 1N0

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

HELENE DESABRAIS (615), ALI NASSER (523), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5, 6, 8, 9, 12, 13, 14, 15 and 16, 2018.

The following inspections were conducted:

Order #001 follow-up Log #022940-17 related to plan of care not providing clear direction to staff regarding bed rails;
Complaint IL-53522-LO/IL-53570-LO/Log #024002-17 related to Family Council;
Compliant Inquiry Log# 022308-17 related to Family Council;

Complaint IL-53900-LO/Log #025405-17 related to alleged physical abuse and improper care of a resident;
Complaint IL54372-IL/Log #027722-17 related to alleged emotional abuse of a resident and responsive behaviours;
Complaint Inquiry IL-53163-LO/IL-53201-LO/Log #022791-17 related alleged verbal abuse of a resident;
Complaint Inquiry IL-52645-LO/Log #020878-17 related to alleged improper care of a resident;
Complaint Inquiry IL-54937-LO/Log #000806-18 related to alleged physical abuse and responsive behaviours;
Critical Incident (CI) #C555-000012-17/Log #026682-17 related to missing controlled substance;
Critical Incident (CI) #C555-000005-18/Log #002658-18 related to alleged sexual abuse of a resident;
Critical Incident (CI) Inquiry #C555-000008-17/Log #023663-17 related to alleged neglect of a resident;
Critical Incident (CI) Inquiry #C555-000013-17/Log #027343-17 related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Maintenance and Housekeeping Manager, the Nutrition Services Manager, the Business Manager, the Pharmacist, the Pharmacist Technician, a Dietary Aide, two Registered Nurses (RNs), a Registered Practical Nurse-Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), five Registered Practical Nurses (RPNs), six Personal Support Workers (PSWs), the representatives for the Family Council and Residents' Council, three family members and over 20 residents.

During the course of the inspection, the inspector(s) also toured the resident home areas and common areas, medication rooms, observed resident care provision, dining services, resident/staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2017_419658_0013	615

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 O.Reg 79/10, s. 101. Dealing with complaints

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).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. 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 was investigated and resolved where possible, with a response that included what the licensee has done to resolve the complaint or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The Ministry of Health and Long Term Care (MOHLTC) received three complaints from a resident related to problems with a resident.

On a specific date, the resident voiced a complaint to the home and a "Ritz Lutheran Villa Formal Complaint Investigation Form" was initiated by the home. The form indicated that the complaint was related to a resident and staff and was ongoing during a specific time of the day. Under "Details of Corrective Action Taken", "see attached" was written, with nothing else other than the attached note from an RN. Under "Complainant Advised", there was nothing written. Under "Complaint/Investigation Interview Form", there was

nothing written. On the front page of the complaint form, was a hand written note stating "No action taken – no specified complaint", signed by the Administrator.

During an interview, the resident said that they reported their concern related to problems with a resident to the management of the home several times and the management had done nothing.

During an interview, the DOC agreed that the complaint received on a specific date from the resident did contain specific complaints related to problems with a resident. The DOC reviewed the complaint form and agreed that there was no documentation of any investigation or follow up and said that the Administrator took and handled this complaint.

During an interview, the Administrator said that it was them who took the complaint and documented that there was no further follow up because there was no specific complaint. The Administrator reviewed the complaint form with the documented complaint received by an RN and agreed that there were specific complaints related to the resident. The Administrator stated that this was the same complaint that this resident had made many times and that they had told the resident that there was nothing that they could do and was not documented on the complaint form.

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 was investigated and resolved where possible with a response that included what the licensee has done to resolve the complaint when the resident submitted a complaint to the home related to problems with a resident. [s. 101. (1)]

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 or operation of the home is investigated and resolved where possible, with a response that include what the licensee has done to resolve the complaint or that the licensee believed the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure that access to areas where drugs were stored was restricted to (i) Persons who may dispense, prescribe or administer drugs in the home, and (ii) The Administrator.

During the Resident Quality Inspection (RQI) it was observed that the nurse's room on a specific floor was used for storage of medication carts, treatment carts, medication dispensing machine, a narcotic destruction box, paper clinical records for the residents and computers that were used for documentation purposes. It was also observed that all staff members in the home had access to this nursing room.

Observations on a specific date, on a specific floor nurse's room, showed a treatment cart that was unlocked with five medicated creams on top of the cart, four drawers were opened and had creams, ointments, suppositories and dressing supplies.

During an interview, an RPN said that the nurse's room was accessible for all staff members including non-registered staff and that the treatment carts should be locked and no creams or ointment should have been placed on top.

During an interview, the DOC said that medication carts, treatment carts, dispensing system and a narcotic destruction box were stored in the nurse's room on the specific floor. The DOC stated that this room was accessible to all staff in the home and not only the persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The licensee has failed to ensure that steps were taken to ensure that access to areas where drugs were stored was restricted to (i) Persons who may dispense, prescribe or administer drugs in the home, and (ii) The Administrator. [s. 130. 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 steps are taken to ensure that access to areas where drugs are stored is restricted to (i) Persons who may dispense, prescribe or administer drugs in the home, and (ii) The Administrator, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that symptoms of infection in residents were monitored on every shift in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices.

During the course of stage one of the RQI, the Inspection Protocol for infection - hospitalization and change in condition was triggered for three residents to be inspected.

A review of the home's policy #ICP-600-12 "Infection Surveillance and Control" reviewed February 2018 stated in part: "Once signs or symptoms of infection are detected in a resident, staff must document observations on that resident every shift in Point Click Care (PCC) progress notes".

A review of the home's "Resident Infection Report Form" on a specific date, for a resident stated that the resident was identified for an infection. A review of the home's "infection Control Surveillance Record" and Outbreak Resident Line Listing on a specific date did not include the resident.

A review of the home's "infection Control Surveillance Record" and Outbreak Resident Line Listing on a specific date included the resident for monitoring. The resident's progress notes also identified that the resident was experiencing signs and symptoms of infection. The progress notes also revealed that signs of infections with the resident were not monitored and documented on every shift.

A review of the resident's progress notes with the DOC and a RN showed that the resident was not monitored prior to isolation on a specific date and not monitored on every shift after this. The DOC and the RN both stated that the expectation was that residents presenting signs and symptoms of infection would be monitored on every shift and documented in the progress notes in PCC.

2. A review of the home's "Resident Infection Report Form" dated October 20, 2017, for a resident, stated that the resident was identified for signs and symptoms of infection, and the "infection Control Surveillance Record" included the resident for monitoring.

A review of the two residents' progress notes on specific dates identified that the residents were experiencing signs and symptoms of infection and were not monitored and documented on every shifts.

During interviews with two RPNs, both stated that residents presenting signs and symptoms of infection would be monitored on every shift and documented in the progress notes in PCC.

A review of the residents' progress notes with the DOC and a RN showed that the residents were not monitored prior to isolation on a specific date and not monitored on every shift after this. The DOC and the RN both stated that the expectation was that residents presenting signs and symptoms of infection would be monitored on every shift and documented in the progress notes in PCC.

The licensee has failed to ensure that symptoms of infection in three residents were monitored on every shift in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices. [s. 229. (5) (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 symptoms of infection in residents are monitored on every shift in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident with a change of five per cent of body weight, or more, over one month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

During stage one of the RQI, Nutrition and Hydration inspection protocol was triggered for a resident indicating weight loss from the census record review and the clinical record of the resident also indicated a weight loss.

A review of home's policy, Weights-Monitoring Resident Weights, Policy # RC-201-109, current revision October 2017, stated "The PSW will reweigh any resident with a weight variance (from previous month) of five per cent or greater within twenty four hours on direction from registered staff. The RAI-Coordinator will audit weights daily from the PSW documentation tool in the PCC to determine percentile variances that may require reweighs or referral. The RN/RPN will request the PSW reweigh the resident if there is a five per cent or greater difference in the resident's weight from the previous month. The RN/RPN will complete an electronic referral to Registered Dietitian or Dietary Manager".

During an interview, the DOC said that the expectation was for the registered nursing staff to complete an audit to ensure all weights and reweighs were taken accordingly and a referral to the RD will be completed once the change in weight was confirmed.

During a clinical record review with the DOC they acknowledged that when the resident had a change of more than five per cent the resident's weight was not retaken and a referral to the RD was not completed. The DOC said that the expectation was for the weight change to have been identified, resident would have been reweighed and if the weight change was confirmed then a referral to the RD would have been completed.

The licensee has failed to ensure that a resident who had a change of five per cent of body weight, or more, over one month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 9th day of March, 2018

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

Original report signed by the inspector.