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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 03, 2019	2019_778563_0011 (A1) (Appeal\Dir#: DR #118)	007254-19	Complaint

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

Amended by MELANIE NORTHEY (563) - (A1)(Appeal\Dir#: DR #118)

Amended Inspection Summary/Résumé de l'inspection modifié

The Compliance Order (CO) #001 and the Compliance Due Date (CDD) was amended based on the Director's Review. CO #001 has a new CDD of June 14, 2019.

Issued on this 3 rd day of June, 2019 (A1)(Appeal\Dir#: DR #118)

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

Original report signed by the inspector.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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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
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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

Amended by MELANIE NORTHEY (563) - (A1)(Appeal/Dir# DR #118)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 15, 2019

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and a Registered Practical Nurse.

The inspector also reviewed the resident's clinical record, the home's investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was not neglected by the licensee or staff.

For the purposes of the Act and this Ontario Regulation 79/10, s. 5, "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."

A letter was received by the Ministry of Health and Long Term Care (MOHLTC) outlining specific events related to a resident. The letter was from the resident's Power of Attorney (POA) and documented that "a number of things occurred" at the Ritz Lutheran Villa which resulted in the resident not receiving services and care in a timely manner. The resident's advanced directives were revised two month prior to this incident, but an old advanced directive form was referenced by the Registered Nurse. The old advanced directives did not outline the most recent instructions specified by the POA.

A "CARE CONFERENCE" progress note in Point Click Care (PCC) documented that a care conference was held for the resident two months prior to this incident. The advanced directives was re-signed and the family requested specific instructions to respond to and maintain the resident's health status.

The "Advanced Directives" Appendix B - 202-01 documented a specific level of "Measures with Additional Treatment Available at The Ritz Lutheran Villa". The "Additional Directions, please specify" section of the form detailed instructions during a specific medical crisis.

The "Profile" tab in PCC documented the POA as "Emergency Contact #1" with a comment that documented the same specific instructions related to the resident's advanced directives.

Progress notes in PCC documented the resident was experiencing a specific medical crisis that required specific medical interventions and the resident did not receive this care at the time it was required.

The Administrator stated they were returning from a meeting when they entered the home and saw the resident exhibiting specific symptoms that required acute medical attention. The Administrator verified that the resident's newly signed advanced directive was not followed with the instruction to send to hospital when the resident was exhibiting specific signs and symptoms.

The Director of Care (DOC) explained the Advanced Directives form was found further back in the chart and the old version was at the front of the chart that indicated the resident was a specific level which did not include the updated

direction to send to hospital for specific signs and symptoms. The DOC stated the advanced directive was updated by the POA and was not followed. Inspector #563 asked the DOC how they got involved in this scenario and the DOC stated that the RPN requested the DOC visit the resident for a second opinion since the RPN and the RN had a differing opinion. The DOC stated it was their opinion was that the resident had to go to hospital and the POA was upset as to why 911 had not been called yet. The DOC verified that the POA then pointed out that the advanced directive being followed was outdated. The DOC also explained that there was no formal protocol, the nurses were to use their clinical skills to assess, then document the assessment and communication in the progress notes. According to the updated Advanced Directive form, the DOC verified the resident should have been transferred to hospital because the resident was presenting with specific symptoms and stated there was almost an hour between the time of the initial symptoms and the arrival of an ambulance.

The RPN stated they remembered working at the time of the resident's change in health status. The RPN shared that they were in the middle of their medication pass when they observed the resident exhibiting specific symptoms. The RPN called for the RN to assess because this was unlike the resident. The RN checked the resident's vital signs, but was hesitant and was looking through the resident's chart to find the advanced directives. The RPN stated they called the DOC because the RN appeared unsure and wanted the DOC consulted to assess for a second opinion. The RPN stated the resident was exhibiting specific symptoms and stated it was longer than it should have been for the ambulance to arrive.

The Ritz Lutheran Villa Advanced Directive/Plan Policy #RC-201-07 with current revision date of October 2016 stated that the purpose of the policy was "to ensure that a resident's Advanced Directive/Plan will be used by staff and the resident's substitute decision maker to assist their decision-making for resident care and services should the resident become incapable of stating their own personal care decisions." "Six weeks post admission and annually thereafter or as the resident/SDM wishes, review the advance care plan and consent to treatment form with the resident/SDM for current and future care needs based on the resident's current health profile."

The licensee failed to ensure that when the resident had specific signs and symptoms, the resident was assessed and monitored routinely, the advanced directives were followed and the resident was transferred by ambulance to hospital immediately for acute care and treatment.

[s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)(Appeal/Dir# DR #118)
The following order(s) have been amended: CO# 001

Issued on this 3 rd day of June, 2019 (A1)(Appeal/Dir# DR #118)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MELANIE NORTHEY (563) - (A1) (Appeal/Dir# DR #118)
Inspection No. / No de l'inspection :	2019_778563_0011 (A1)(Appeal/Dir# DR #118)
Appeal/Dir# / Appel/Dir#:	DR #118 (A1)
Log No. / No de registre :	007254-19 (A1)(Appeal/Dir# DR #118)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 03, 2019(A1)(Appeal/Dir# DR #118)
Licensee / Titulaire de permis :	Ritz Lutheran Villa 16 Lot Road 164 5#, R.R. #5, MITCHELL, ON, N0K-1N0
LTC Home / Foyer de SLD :	Ritz Lutheran Villa 4118A Road 164, R.R. #5, MITCHELL, ON, N0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Renaud

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Ritz Lutheran Villa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

(A1)(Appeal/Dir# DR #118)
The licensee must be compliant with s. 19 (1) of the Long Term Care Homes Act.

Specifically, the licensee must:
a) Ensure all residents have an updated advanced directive as part of their clinical record;
b) Ensure that staff and others who provide direct care to residents are kept aware of the residents advanced directives and have convenient and immediate access to it;
c) Ensure that staff are educated on the Ritz Lutheran Villa Advanced Directive/Plan Policy #RC-201-07 with the current revision date of October 2018; and
d) Ensure that staff provide timely treatment upon a change in a resident's medical condition.

Grounds / Motifs :

1. The licensee failed to ensure that a resident was not neglected by the licensee or staff.

For the purposes of the Act and this Ontario Regulation 79/10, s. 5, "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."

A letter was received by the Ministry of Health and Long Term Care (MOHLTC) outlining specific events related to a resident. The letter was from the resident's Power of Attorney (POA) and documented that "a number of things occurred" at the Ritz Lutheran Villa which resulted in the resident not receiving services and care in a timely manner. The resident's advanced directives were revised two month prior to this incident, but an old advanced directive form was referenced by the Registered Nurse. The old advanced directives did not outline the most recent instructions specified by the POA.

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directive was updated by the POA and was not followed. Inspector #563 asked the DOC how they got involved in this scenario and the DOC stated that the RPN requested the DOC visit the resident for a second opinion since the RPN and the RN had a differing opinion. The DOC stated it was their opinion was that the resident had to go to hospital and the POA was upset as to why 911 had not been called yet. The DOC verified that the POA then pointed out that the advanced directive being followed was outdated. The DOC also explained that there was no formal protocol, the nurses were to use their clinical skills to assess, then document the assessment and communication in the progress notes. According to the updated Advanced Directive form, the DOC verified the resident should have been transferred to hospital because the resident was presenting with specific symptoms and stated there was almost an hour between the time of the initial symptoms and the arrival of an ambulance.

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The licensee failed to ensure that when the resident had specific signs and symptoms, the resident was assessed and monitored routinely, the advanced directives were followed and the resident was transferred by ambulance to hospital

immediately for acute care and treatment.
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 2019(A1)
(Appeal/Dir#: DR #118)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3 rd day of June, 2019 (A1)(Appeal/Dir# DR #118)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MELANIE NORTHEY (563) - (A1) (Appeal/Dir# DR #118)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : London Service Area Office