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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 9, 2023

Inspection Number: 2023-1504-0003

Inspection Type:
Complaint
Post-Occupancy
Follow up
Critical Incident System

Licensee: Ritz Lutheran Villa

Long Term Care Home and City: West Perth Village, Mitchell

Lead Inspector	**Inspector Digital Signature**
Christina Legouffe (730)	

Additional Inspector(s)
Tatiana Pyper (733564)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24, 25, 26, 29, 30, 31, 2023 and June 1, 2, 2023
The inspection occurred offsite on the following date(s): June 6, 2023

The following intake(s) were inspected:

- Intake: #00018694, a follow up to Compliance Order #002 from inspection #2022_1504_0001 related to FLTCA, 2021 s. 5, with a compliance due date of November 9, 2022.
- Intake: #00085084, a complaint related to staffing levels, food quality, and air temperatures.
- Intake: #00086466, related to a fall resulting in an injury.
- Intake: #00087245, related to an injury of unknown origin.
- Intake: #00088279, a Post Occupancy Inspection

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2022-1504-0001 related to FLTCA, 2021, s. 5 inspected by Christina Legouffe (730)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] AIR CONDITIONING REQUIREMENTS

NC #001 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 23.1 (3) 1., served on June 1, 2023
Please refer to inspection 2023-1504-0004 for Immediate Compliance Order (ICO) follow up 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 #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's plan of care provided staff with clear direction related to bathing.

Summary and Rationale
A resident fell, had an injury, and needed to wear a medical device. Their plan of care said in one section that the resident was to have a specific method of bathing, but another section included a second method of bathing and the resident was being bathed both ways.

A Physiotherapist (PT) said that the resident's plan of care did not provide clear direction for staff about how they were to bathe.

After speaking with the Inspector, the PT reassessed the resident and their plan of care was revised to provide clear direction for bathing.

Sources: Resident clinical records; interviews with a PT and other relevant staff. [730]

Date Remedy Implemented: May 31, 2023

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with the home's "Food Temperatures – Point of Service" Policy.

Ontario Regulation 246/22 s. 11 (1) (b) stated that the licensee was required to ensure that written policies and protocols were developed for the nutritional care and dietary services and hydration

program and ensure they were complied with.

Specifically, staff did not comply with the "Food Temperatures – Point of Service" Policy, which was part of the home's Nutritional Care and Hydration Program.

Summary and Rationale
A complaint was summitted to the Ministry of Long-Term Care about food temperatures and food quality.

Food Temperatures were not recorded for lunch and dinner served one day in a dining room. Temperatures of all foods were to be measured and documented before meal service by dietary aides.

The Director of Nutrition Services said that food temperatures should have been taken and documented before being served to the residents in a dining room, but were not.

There was a risk to residents that foods were not served at appropriated temperatures when the temperatures of food were not taken and documented.

Sources: Review of Service and Delivery Worksheets, the "Food Temperatures – Point of Service" Policy, and interview with the Director of Nutrition Services.
[733564]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.

The licensee has failed to ensure that the Director was immediately informed of a breakdown of major equipment in the home that affected the provision of care or the safety, security, or well-being of one or more residents, for a period greater than six hours.

Summary and Rationale
A resident complained to an Inspector that the air conditioning in the home was not working properly. The thermostat in the resident’s room read 27 degrees Celsius.

After Inspectors told the management of the home that the air conditioning was not at a comfortable

level in the resident rooms, the Building Services Director (BSD) contacted a Heating, Ventilation, and Air Conditioning (HVAC) technician and they came to the home to repair the affected air conditioning unit, however, the unit was still not working at full capacity and that the HVAC technicians needed to come back to the home to do more repairs.

A Critical Incident System (CIS) report, related to environmental hazards, was not immediately submitted to the Director by the home's Director of Care (DOC).

Sources: Observations of resident rooms, interviews with a resident, Building Services Director and Director of Care.
[733564]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care, related to falls prevention interventions, was provided to a resident as specified in the plan.

Summary and Rationale
A resident was at high risk for falls. During an observation of the resident an Inspector saw that one of the resident's falls preventions interventions was not in place.

A Personal Support Worker (PSW) said that the resident's falls prevention interventions should have been in place at the time of the observation.

Sources: Clinical records for a resident, an observation of the resident, and interviews with a PSW and other staff. [730]

B) The licensee has failed to ensure that the care set out in the plan of care related to falls prevention interventions was provided to a resident as specified in the plan.

Summary and Rationale
A Critical Incident Systems (CIS) report was submitted related to a fall for a resident. The resident had another fall after that time.

A Registered Practical Nurse (RPN) said that they went to help the resident when they fell and said that one of the resident's falls prevention interventions was not in place, but should have been.

There was a risk that the resident's fall was not discovered immediately due to the resident's falls prevention intervention not being in place.

Sources: resident clinical records, and interviews with an RPN and other staff. [730]

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident, related to monitoring an injury, was documented.

Summary and Rationale
The home reported, in a critical incident, that a resident had an injury.

The resident needed a medical device for their injury. The resident's care plan was updated to include monitoring of the injury. There was no monitoring of the injury documented for 13 days.

The Director of Care (DOC) said that it was an expectation that there was documentation of the monitoring of the injury on every shift.

There was a risk that the resident's injury was not monitored, when the monitoring of the injury was not documented.

Sources: Resident clinical record, interviews with the DOC and other staff. [730]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (iii)

The licensee has failed to ensure that a resident's injury, was immediately investigated.

O. Reg 246/22 s. 115 (3) states: The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Summary and Rationale
It was reported to the Director, by the home, that a resident had an injury.

The Assistant Director of Care (ADOC) said no documented investigation was completed.

Three Personal Support Workers (PSWs) and a Registered Practical Nurse, who worked with the resident around the time the injury was thought to have happened, said that management had not interviewed them about the injury.

There was a risk to the resident as the cause of the injury was not investigated, not identified, and not acted on.

Sources: Critical Incident Report, clinical records for a resident and interviews with the ADOC and other staff.

[730]

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.

The licensee failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home, including a lounge, dining area, or corridor.

Summary and Rationale
A resident complained to an Inspector that the air conditioning in the home was not working properly. The thermostat in the resident's room read 27 degrees Celsius.

A Registered Practical Nurse (RPN) said that there had been complaints by residents and visitors of high temperatures in the home over the past few days.

The Resident Assessment Instrument (RAI) Coordinator said that air temperatures were documented by a Registered Nurse (RN) in the Point Click Care (PCC) Companion Application in one common room on each floor of the home.

An Inspector reviewed the home's temperature records with Resident Assessment Instrument (RAI) Coordinator and saw that air temperatures were not documented on any date in at least one resident common area on each floor of the home.

There was a risk that high temperatures in the home would not be identified when the home failed to measure and document the air temperature in at least one resident common area on each floor of the home.

Sources: Observations of resident rooms, interviews with a resident, the Resident Assessment Instrument Coordinator, a Registered Practical Nurse and the Director of Care.
[733564]

WRITTEN NOTIFICATION: Air temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 3.

The licensee failed to ensure that the air temperatures in at least two resident rooms in different areas of the home and in one resident common area on every floor of the home, including a lounge, dining area, or corridor, were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Summary and Rationale
A resident complained to an Inspector that the air conditioning in the home was not working properly.

The thermostat in the resident's room read 27 degrees Celsius.

The Resident Assessment Instrument (RAI) Coordinator said that air temperatures were to be documented by a Registered Nurse (RN) in the Point Click Care (PCC) Companion Application at 0730, 1500, and 1900 hours.

An Inspector reviewed the home's temperature records with Resident Assessment Instrument (RAI) Coordinator and saw that air temperatures were not documented once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

There was a risk that high temperatures in the home would not be identified when the home failed to measure and document the air temperature in the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in one resident common area on every floor of the home, including a lounge, dining area, or corridor.

Sources: Observations of resident rooms, interviews with a resident, the Resident Assessment Instrument Coordinator, and the Director of Care.
[733564]

WRITTEN NOTIFICATION: Required programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with. Specifically, staff did not comply with the licensee's "Head Injury Routine" protocol.

Summary and Rationale
The home submitted a Critical Incident System (CIS) report related to a resident, who had a fall.

A Head Injury Routine (HIR) for a resident was started, but was not completed for all required checks.

The Assistant Director of Care (ADOC) said that the resident's HIR, was not completed as per the protocol of the home.

The home's failure to follow their "Head Injury Routine" protocol put the resident at risk, as staff had the potential to miss post fall injuries if regular assessments were not completed as required.

Sources: Review of resident clinical records, the home's "Head Injury Routine", and interviews with the ADOC and other staff. [730]

WRITTEN NOTIFICATION: Required programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The licensee has failed to comply with the home's pain management policy related to pain assessment and management, included in the required pain management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the pain management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Pain Management and Assessment" policy.

Summary and Rationale
The home reported that a resident had an injury.

The home's "Pain Management and Assessment" policy said that a pain assessment would be documented in Point Click Care (PCC) with any new pain and upon readmission. The home's "Re-admission/post Hospitalization/Return from Hospital Checklist" said that a pain assessment was to be completed immediately upon a residents' return.

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) said that the resident showed signs of pain before the discovery their injury.

No pain assessments were documented in PCC for the resident when they showed new pain related to their injury or when they returned to the home.

The Director of Care (DOC) said that pain assessments were not completed, as required, for the resident

upon exhibiting new pain and upon return to the home.

There was a risk that the resident's pain was not managed as a result of pain assessments not being completed as required.

Sources: Resident clinical record, the home's policy "Pain Management and Assessment," and interviews with a PSW, RPN, DOC, and other staff. [730]

WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, who was at risk for altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return to the home.

Summary and Rationale
The home reported, in a critical incident, that a resident had an injury.

The resident's plan of care said that they were at risk for altered skin integrity.

No skin assessment was completed when the resident returned to the home.

A Registered Nurse (RN) said that a head to toe skin assessment should have been completed when the resident returned to the home, but was not.

There was a risk that the resident could have had altered skin integrity that was not identified by the home, when a skin assessment was not completed when they returned to the home.

Sources: Resident clinical record, interviews with a RN and other staff. [730]

WRITTEN NOTIFICATION: Food production

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)

The licensee has failed to ensure that all food and fluids in the food production system were prepared,

stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

Summary and Rationale

A complaint was received by the Ministry of Long-Term Care, which had concerns related to food quality.

During an observation of the lunch service, chicken served to residents appeared to be burnt. Residents told Inspectors that the chicken was overcooked, burnt, and did not taste good. A resident said that the chicken was too dry to eat.

The Director of Nutrition Services said that the chicken served to the residents did not meet the food quality expectations of the home.

Sources: Meal observations in the home, interviews with residents and the Director of Nutrition Services.
[733564]

COMPLIANCE ORDER CO #001 Air temperature

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. Retrain all Registered Nurses (RNs) on the home's policies and procedures for measuring and documenting air temperatures. Ensure the training is documented, including the date the training occurred, the content of the training, and the staff members who completed the training.
2. Perform weekly audits of the air temperature records for 4 weeks, or until the order is complied; and document the audits, including who performed the audit, the date it was performed and actions made based on the result of the audit.

Grounds

The licensee has failed to ensure that the air temperatures were measured and documented in writing in at least two resident bedrooms in different parts of the home.

Summary and Rationale

A resident complained to an Inspector that the air conditioning in the home was not working properly. The thermostat in the resident's room, read 27 degrees Celsius.

A Registered Practical Nurse (RPN) said that there had been complaints by residents and visitors of high temperatures in the home over the past few days.

The Resident Assessment Instrument (RAI) Coordinator said that air temperatures were documented by a Registered Nurse (RN) in the Point Click Care (PCC) Companion Application in at least two resident bedrooms in different parts of the home.

An Inspector reviewed the home's temperature records with Resident Assessment Instrument (RAI) Coordinator and saw that air temperatures were not documented on any date in at least two resident bedrooms in different parts of the home.

High temperatures in resident bedrooms on the second floor of the home were not identified immediately when the home failed to measure and document the air temperature in at least two resident bedrooms in different parts of the home.

Sources: Observations of resident rooms, interviews with a resident, the Resident Assessment Instrument Coordinator, a Registered Practical Nurse and the Director of Care.

[733564]

This order must be complied with by

July 7, 2023

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Reinspection of outstanding CO #002, from inspection #2022-1504-0001 with Compliance Due Date November 9, 2022, which was originally follow up on during inspection #2023-1504-0002, which took place on January 9, 10, 11, and 12, 2023.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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