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: December 12, 2023	
Inspection Number: 2023-1504-0007	
Inspection Type: Critical Incident	
Licensee: Ritz Lutheran Villa	
Long Term Care Home and City: West Perth Village, Mitchell	
Lead Inspector Cheryl McFadden (745)	**Inspector Digital Signature** Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2023.12.21 13:24:54 -05'00'
Additional Inspector(s) Kristen Murray (731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21, 23, 27, 29, 2023

The following intake(s) were inspected:

- Intake: #00090895–CIS #3007-000043-23: related to prevention of abuse and neglect.
- Intake: #00098555–CIS #3007-000076-23: related to improper care.
- Intake: #00100085–CIS #3007-000080-23: related to fall's prevention.

The following intakes were completed during this inspection related to fall's prevention:

- Intake: #00094076–CIS #3007-000054-23

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- Intake: #00097027–CIS #3007-000066-23
- Intake: #00098050–CIS #3007-000073-23
- Intake: #00100059–CIS #3007-000079-23

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: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that when a resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident sustained an injury from a fall. Upon return to the home, the resident had a transfer assessment completed and their transfer status changed. The resident's care plan, and the logo in the resident's room did not reflect the change in change in transfer status based on the assessment. A Personal Support Worker (PSW) confirmed the resident's required transfer status.

The home's falls prevention management policy stated that after a resident has sustained a fall, staff were to re-evaluate the residents care plan. In interviews with the Falls Lead and the Director of Care (DOC), they both acknowledged that the resident's care plan and the logo in their room should have been updated to reflect the change in transfer status.

There was increased risk to the resident related to the plan of care not being reviewed and revised when their care needs changed.

Sources: CIS 3007-000080-23; The home's falls policy "Falls Prevention Management – 1222", number RC-201-49 (last revised December 1, 2022); Clinical records for a resident, including progress notes, assessments, and plan of care; Observations of the resident's transfer logo in their room; and Interviews with a PSW, Falls Lead, and DOC. [731]

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the Falls Prevention Management Program in the home for the Head Injury Routine (HIR) for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the Falls Prevention Management – 1222 policy, number RC-201-49, last revised December 1, 2022, was complied with as a part of the Falls Prevention and Management Program.

Rationale and Summary
A resident stated to staff that they sustained a fall. No HIR was completed for the resident related to the fall.

The home's falls prevention management policy identified that if a resident had sustained a fall, registered staff were to initiate HIR if the resident fall was unwitnessed, and monitor neurological status post-fall for signs of neurological changes, including assessing level of consciousness, vital signs, and pupillary reaction at specific intervals after the fall.

In interviews with the Falls Lead and the Director of Care (DOC), they both acknowledged that staff should have completed HIR when the resident stated they fell.

There was increased risk to the resident related to HIR not being completed for the resident after they stated they sustained a fall.

Sources: The home's falls policy "Falls Prevention Management – 1222", number RC-201-49 (last revised December 1, 2022); Clinical records for a resident, including progress notes, paper chart, and assessments; and Interviews with Falls Lead, and DOC. [731]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument, specifically designed for falls.

Rationale and Summary
A resident stated to staff that they sustained a fall. No post-fall assessment was completed for the resident related to the fall.

The home's falls prevention management policy stated that after a resident had sustained a fall, staff were to complete a post-fall assessment. In interviews with the Falls Lead and the Director of Care (DOC), they both acknowledged that staff should have completed a post-fall assessment when the resident stated they fell.

There was increased risk to the resident related to not having a post-fall assessment completed after the resident stated they sustained a fall.

Sources: The home's falls policy "Falls Prevention Management – 1222", number RC-201-49 (last revised December 1, 2022); Clinical records for a resident, including progress notes, and assessments; and Interviews with Falls Lead, and DOC. [731]

COMPLIANCE ORDER CO #001 Plan of Care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Perform weekly audits on a specific resident to ensure the proper diet type and texture are served and identified in meal suite.
2) Continue the weekly audits and keep a documented record of them until a follow up inspection has been conducted.

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary

During a CIS inspection, the home confirmed that a resident had an incident that

required medical intervention.

Record review of the clinical record for the resident identified they were to receive a specific diet per their plan of care.

A review of Dining Selection Tool policy documented the Food Service Worker would plate meals according to information on the dining selection tool as part of Meal Suite using a table by table sequence unless otherwise stated in the residents plan of care.

The Director of Care and the Nutrition and Food Services Manager stated the resident had received a food item that was not identified as part of their specific diet interventions as planned, and resulted in a incident that caused a negative outcome for the resident and put them at risk during the meal service.

There was high risk to the resident related to receiving a menu item that was not identified as part of the plan of care for food and nutrition.

Sources: Clinical records for the resident, including care plan and assessments and interviews with Director of Care and Nutrition and Food Services Manager.
[745]

This order must be complied with by January 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP 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 AMP.

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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

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.