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
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Original Public Report

Report Issue Date: October 23, 2024
Inspection Number: 2024-1504-0004
Inspection Type: Critical Incident
Licensee: Ritz Lutheran Villa
Long Term Care Home and City: West Perth Village, Mitchell

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 16, 17, 18, 21, and 22, 2024
The inspection occurred offsite on the following dates: October 18 and 22, 2024

The following intakes were inspected:

- Intake: #00121915 – CIS # 3007-000084-24 Related to Prevention of Abuse and Neglect.
- Intake: #00123402 -CIS# 3007-000096-24 Related to Falls Prevention and Management
- Intake: #00124724 – CIS# 3007-000105-24 Related to Prevention of Abuse and Neglect.
- Intake: #00127218 -CIS# 3007-000121-24 Related to Infection Prevention and Control.
- Intake: #00128257 – CIS# 3007-000126-24 Related to Food, Nutrition, and Hydration.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of alleged abuse to a resident by another resident was immediately reported to the Director.

Rationale and Summary

The home submitted a Critical Incident report a day after an incident of the alleged abuse of a resident by another resident.

A Registered Nurse (RN) said that they did not immediately report the incident of alleged abuse between the residents to the Director.

The Director of Care (DOC) stated that it would be the expectation that all incidents

related to abuse would be reported immediately to Ministry of Long-term Care and staff were provided with education that any suspected or alleged abuse must be immediately submitted.

Failure to immediately report an allegation of abuse to the Director, placed the resident at risk for further harm or abuse.

Sources: Review of Critical Incident System report (CIS), interview of RN and the DOC and progress notes of residents. [705241]