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

Public Report

Report Issue Date: December 13, 2024

Inspection Number: 2024-1504-0005

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 date(s): November 22, 25, 26, 27, 28, 29, 2024

The following intake(s) were inspected:

- Intake: #00128669 - CIS #3007-000129-24 - Related to prevention of abuse and neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A) The licensee failed to ensure that resident's right to be treated with courtesy and respect, in a manner that fully recognizes their inherent dignity, worth, and individuality, was upheld during personal care provided by a Personal Support Worker (PSW) .

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director, detailing an incident of staff-to-resident alleged abuse during the night shift in the home.

The CIS report stated that PSW engaged in alleged physical and verbal abuse towards a resident .

The resident's progress note, recorded by Registered Nurse (RN), indicated that it was reported to them that there was the alleged verbal and physical abuse by a PSW to a resident during bedtime care.

In an email to the home's Director of Care (DOC) and Assistant Director of Care (ADOC), a PSW reported that another PSW had yelled at the resident and was

forcefully while providing care.

In a phone interview, the PSW confirmed witnessing the inappropriate care provided by the other PSW to the resident.

During an interview, the DOC confirmed that the home's investigation substantiated the inappropriate care to the resident by the PSW.

Failure to ensure that the resident was treated with courtesy and respect during care posed a moderate risk to their safety and well-being.

Sources: CIS report, resident progress note, PSW email to the home, and interviews with staff and DOC.

B) The licensee failed to ensure that a resident's right to be treated with courtesy and respect, in a manner that fully recognizes their inherent dignity, worth, and individuality, was upheld during personal care provided by Personal Support Worker (PSW).

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director, detailing an incident of staff-to-resident alleged abuse during the night shift in the home.

The CIS report stated that a PSW witnessed another PSW allegedly become annoyed with a resident while repositioning them and used derogatory terms and curse words.

The resident's progress note, recorded by the Registered Nurse (RN), indicated that the PSW reported the alleged verbal abuse during care by the other PSW.

In an email to the home's Director of Care (DOC) and Assistant Director of Care (ADOC), it was reported that the PSW provided inappropriate care and instructions to the resident.

In a phone interview, a PSW confirmed witnessing the inappropriate care provided by the other PSW to the resident.

During an interview, the DOC confirmed that the home's investigation substantiated the inappropriate care to the resident by the PSW.

Failure to ensure that the resident was treated with courtesy and respect during care posed a moderate risk to their safety and well-being.

Sources: CIS report, resident progress note, PSW email to the home, and interviews with staff and DOC.

C)The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality was fully respected and promoted.

Rationale and Summary

The Director received a Critical Incident System (CIS) report related to an alleged staff abuse towards a resident.

During the home's investigation, a statement from the resident's roommate indicated that they heard the PSW repeating after and taunting the resident. The home's policy indicated the inherent rights of a resident will be formally recognized along with the responsibilities to uphold these rights.

A PSW stated they heard and observed the other PSW mimicking and mocking the resident.

Director of Care (DOC) stated that the PSW treatment of the resident was not respectful and did not support the resident's rights to be treated with dignity.

Failure to ensure that the resident was treated with respect posed the risk of their dignity not being respected.

Sources: Home's investigation notes, interviews with staff.

D) The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality was fully respected and promoted.

Rationale and Summary

The Director received a Critical Incident System (CIS) report related to an alleged staff abuse involving a resident.

During an interview, the resident stated that a PSW would come to their room and turn off their call bell and would not ask them what they required. They stated that the PSW did this multiple times and would not acknowledge them. The resident stated that they felt disrespected and less of a person by the treatment that they received from the PSW.

A PSW stated they had to provide care for the resident because the other PSW had ignored the resident's needs. They stated that the resident then requested not have the other PSW return to their room to provide any care to them.

Director of Care (DOC) stated that the PSW treatment of the resident was not respectful and did not support the resident's rights to be treated with dignity.

Failure to ensure that the resident was treated with respect posed the risk of their dignity not being respected.

Sources: Home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The licensee has failed to ensure that a resident was protected from verbal abuse by a Personal Support Worker (PSW).

Summary and Rationale

Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

The home's Abuse and Neglect (Zero Tolerance) Policy with a review date of October 31, 2025, also included this same definition. The home's policy listed examples of verbal abuse as "inappropriate tone of voice, abusive language, yelling, swearing, rude, offensive or sexual comments or gestures".

A Resident reported to staff in the home on a specific date, that they were upset with a PSW because they had used an aggressive tone towards them during care. Noted from the Critical incident system (CIS) report submitted by the home, the registered nurse (RN) removed the PSW from completing further care for the resident.

During an interview, the resident stated they felt disrespected by the PSW, and felt fearful of them.

The home's investigation notes stated that when the resident rang the call bell during the night, the PSW spoke in an aggressive tone, used profane words and told the resident not to ring the call bell.

Director of Care (DOC)confirmed the allegations of verbal abuse during the home's investigation and stated that the resident was cognitively competent.

There was a risk to the resident when they were not protected from verbal abuse by the PSW.

Sources: the home's investigation notes, home's Abuse and Neglect (Zero Tolerance) Policy, interview and clinical records of the resident, and interviews with DOC and staff.

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

1) Re-educate all personal support worker (PSW) staff to ensure they understand the home's process for reporting incidents of alleged abuse and/or neglect.

2) Re -educate all PSW staff on whistle blower protection.

3) Keep records of the education provided, the content of the education, who attended the education, the date it was held, staff signatures indicating they

attended, and who provided the education.

Grounds

The licensee has failed to ensure that incidents of abuse to multiple residents of the home by a former staff member was immediately reported to the Director.

Rationale and Summary

On a specific date multiple residents in the home suffered alleged abuse from a PSW. The incidents of alleged abuse were reported and submitted to the Ministry of Long-term Care (MLTC) a day after the occurrence.

A Personal support worker (PSW) stated that they witnessed the abuse on the specific date by the other PSW, but they were not comfortable reporting at the time. They stated that they sent an e-mail to the home's management the next day.

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 residents at risk for further harm or abuse.

Sources: Review of Critical Incident System report (CIS) , interview with staff and the DOC and review of residents progress notes.

This order must be complied with by January 29, 2025

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Telephone: (800) 663-3775

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.