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: April 16, 2025

Inspection Number: 2025-1504-0002

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: April 8 to 11 and 14 to 16, 2025.

The following intakes were inspected:

- Intake #00142081/Critical Incident System Report (CIS) #3007-000015-25 regarding allegations of resident to resident abuse
- Intake #00142636/CIS #3007-000017-25 regarding infection prevention and control
- Intake #00142981/CIS #3007-000020-25 regarding infection prevention and control
- Intake #00143057/CIS #3007-000021-25 regarding allegations of improper care of a resident

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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) 19. ii.
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:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that three residents had the right to refuse consent to a medication. The three residents subsequently received the medication without consent.

Sources: Clinical records including Orders, Electronic Treatment Administration Records, Progress Notes, Medication Incident Forms, and the homes policy titled "Antiviral Medication" (Revised June 17, 2024)

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 licensee has failed to ensure that the care set out in the plan of care was provided to a resident when staff #107 repositioned the resident without the assistance of a second person.

The long term care home's (LTCH) investigation confirmed that staff #107 was observed on video repositioning a resident without assistance, contrary to the resident's established plan of care. In an interview with staff #106, they verified the care set out in the plan of care was not provided to the resident when staff #107 repositioned the resident without the assistance of a second person.

Sources: Record review of resident's electronic medical record, Critical Incident Report (CIS) #3007-000021-25, (LTCH) investigation file typed document; and interview with staff #106

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to report the suspicion of improper care of a resident when their family reported their concerns to the home regarding several allegations.

The long term care home's (LTCH) investigation file contained a typed document, outlining concerns from the resident's family regarding several allegation as well as supporting details from a conversation that occurred with the family in March, 2025. In an interview with staff #106, they verified that the LTCH delayed reporting the allegations of improper care to the Director until they had completed their investigation and determined the allegations were founded.

Sources: Record review of resident's electronic medical record, Critical Incident Report (CIS) #3007-000021-25, (LTCH) investigation file typed document, LTCH policy #RC-201-57 Activities of Daily Living (ADL); and interview with staff #106

WRITTEN NOTIFICATION: Personal Support Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (1) (b)
Nursing and personal support services
s. 35 (1) This section and sections 36 to 52 apply to,
(b) the organized program of personal support services required under clause 11 (1) (b) of the Act.

The licensee has failed to comply with the home's nursing and personal support services program when staff #104 did not follow the directions in the home's Activities of Daily Living (ADL) policy for personal hygiene. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nursing and person support services program are complied with. Specifically, the home's Activities of Daily Living (ADL) policy indicated that when

performing personal hygiene tasks, staff are to follow the directions outlined in the policy.

A typed document dated in March, 2025 in the Long Term Care Home's (LTCH) investigation file outlined that PSW #104 was observed not following the home's Activities of Daily Living (ADL) policy for personal hygiene. Staff #106 verified in an interview that PSW #104 did not comply with the long term care home's (LTCH) policy #RC-201-57 Activities of Daily Living (ADL).

Sources: Record review LTCH policy #RC-201-57 Activities of Daily Living (ADL), Critical Incident Report (CIS) #3007-000021-25, (LTCH) investigation file typed document; and interview with staff #106

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff #101 and #102 used safe transferring techniques during a transfer of a resident in March, 2025.

The resident's electronic medical record directs staff to use two persons during transfers. A typed document in the Long Term Care Home's (LTCH) investigation file outlines that staff #101 and #102 were observed transferring a resident. During the transfer, staff #102 left the room. Although the staff returned shortly, staff #106 verified in an interview that staff #101 and #102 did not use safe transferring

techniques during the transfer of the resident.

Sources: Record review of the resident's electronic medical record, (LTCH) investigation file typed document; and interview with staff #106

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with. In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that routine practices and additional precautions were followed when staff provided care to a resident in March, 2025.

The resident's electronic medical record indicates the resident was isolated and a typed document in the Long Term Care Home's (LTCH) investigation file outlined that staff #108 and #109 were observed not following additional precautions when providing care to the resident.

Sources: Record review of resident's electronic medical record, Critical Incident Report (CIS) #3007-000021-25 and (LTCH) investigation file typed document