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

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Public Report

Report Issue Date: May 28, 2025

Inspection Number: 2025-1504-0004

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 date(s): May 20, 22-23, and 26-28, 2025

The following intake was inspected:

- Critical Incident (CI) #3007-000040-25 related to prevention of abuse and neglect.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC # 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 failed to ensure that a resident was protected from sexual abuse by another resident on four occurrences.

A resident touched another resident non-consensually on four occurrences during a month and a half period. Both residents were determined to be unable to consent to touching of a sexual nature and to have had a previous history of non-consensual touching with other residents. Interventions were in place at the time of the incidents which directed staff to separate the residents should any touching occur.

Sources: Observations of residents and the care being provided to them in the home; the resident's clinical records, including care plans, assessments, progress notes, and risk management incidents; CI reports; and staff interviews.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC # 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 failed to ensure that when there was an allegation of sexual abuse

towards a resident, it was immediately reported to the Director.

Personal support staff witnessed an incident of non-consensual touching of a sexual nature between residents. Registered staff were not made aware of the incident until the following day when it was first reported by a Personal Support Worker (PSW) and a CI report was subsequently submitted to the Director.

Sources: the resident's clinical record, including care plan, assessments, progress notes, and risk management incident; CI report; and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure that the outcomes of the care set out in the plan of care related to responsive behaviours were documented for two residents.

In accordance with the home's policy related to documentation, interdisciplinary team members were directed to document in a resident's progress notes and electronic Treatment Administration Record (TAR) and personal support staff to document all pertinent resident care delivery information prior to the end of their shift under the resident's applicable tasks on Point of Care (POC).

A) It was identified in a residents plan of care that they had potential to exhibit responsive behaviours and staff were directed to document any inappropriate behaviours and ensure nursing staff were immediately notified. Behavioural

Supports Ontario-Dementia Observation System (BSO-DOS) charting was completed for the resident over a five day period and it was documented that they exhibited responsive behaviours. During this same period there was no documentation in their progress notes or under their scheduled tasks in POC indicating they had exhibited these responsive behaviours.

Sources: the resident's clinical record, including care plan, assessments, progress notes, BSO-DOS charting, and tasks; the home's documentation policy; and staff interviews.

B) It was identified in a residents plan of care that they had potential to exhibit responsive behaviours and staff were directed to provide additional support and monitoring to the resident as needed. Following a critical incident, an order was scheduled for them which directed staff to provide increased monitoring and document if behaviours were observed. Documentation related to whether behaviour was observed was not completed when scheduled on their TAR on one occurrence.

Sources: the resident's clinical record, including care plan, progress notes, TAR, and tasks; the home's documentation policy; and staff interviews.

C) It was identified in a residents plan of care that they had potential to exhibit responsive behaviours and staff were directed to document any inappropriate behaviours. There were four critical incidents documented in the residents progress notes and in the homes risk management system where they had been identified to exhibit responsive behaviours. On these dates there was no documentation under their scheduled tasks in POC indicating they had exhibited these responsive behaviours.

Sources: the resident's clinical record, including care plan, progress notes, risk

management, and tasks; CI reports; the home's documentation policy; and staff interviews.