Ontario

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**London District**
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# Public Report

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| **Report Issue Date:** July 14, 2025 |
| **Inspection Number:** 2025-1504-0005 |
| **Inspection Type:**<br>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): July 8, 9, 10, 14, 2025

The following intake(s) were inspected:

- Intake: #00149285 - Critical Incident System Report 3007-000049-25 related to a fall.
- Intake: #00149528 - Critical Incident System Report 3007-000050-25 related to a fall.

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

Falls Prevention and Management

## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**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 a resident's falls prevention intervention was in place as per their plan of care. A staff member put the intervention in place after they became aware that it was not in place.

**Sources:** An observation , clinical records for a resident and an interview with a staff member.

Date Remedy Implemented: July 8, 2025

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (1) (c)**
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident provided clear direction for staff. The plan of care directed staff to follow a specific regimen for care, as outlined in Point of Care (POC), however, POC did not include any tasks related to the specified care.

**Sources:** Clinical records for a resident including their written care plan and tasks, and interviews with the Restorative Care Lead and other staff.

## WRITTEN NOTIFICATION: Protection from certain restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 34 (1) 3.**
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
3. Restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

The licensee has failed to ensure that a resident was not restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39. Staff used an intervention, as a falls prevention intervention, which in turn restrained the resident. The intervention was not assessed as a restraint, ordered for the resident, or consented to by the resident's substitute decision maker as a restraint.

The home's policy titled "Restraint and PASD Management" (Revised January 17, 2025), defined a physical/mechanical restraint as a physical device adjacent to the resident's body, that the resident could not remove easily and that restricted the resident's freedom of movement and noted that physical restraints were not a fall prevention strategy.
**Sources:** Observation of a resident, clinical records including progress notes, the home's policy titled "Restraint and PASD Management", and interviews with staff.