



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 12, 2016	2016_229213_0034	028485-16	Resident Quality Inspection

Licensee/Titulaire de permis

RITZ LUTHERAN VILLA
R.R. #5 MITCHELL ON N0K 1N0

Long-Term Care Home/Foyer de soins de longue durée

MITCHELL NURSING HOME
184 NAPIER STREET, S.S. #1 MITCHELL ON N0K 1N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RHONDA KUKOLY (213), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 27, 28, 29, 30, October 3, 2016

Critical incident #2689-000006-16, Log #016468-16 related to an electrical fire was inspected concurrently within the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Director of Care from Ritz Lutheran Villa, the Program Manager, the Manager of Dietary Services, the Manager of Building Services, a Registered Nurse, a Registered Dietitian, three Registered Practical Nurses, three Personal Support Workers, a Program Support Staff, over 20 residents and four family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Residents' Council

Safe and Secure Home

Skin and Wound Care



During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

**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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).**

Findings/Faits saillants :



1. The license failed to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

On September 28, 2016, an observation of the rooms of residents #005 and #001 showed that both residents had bed rails in use.

Personal Assistive Service Device (PASD) Policy # RESI-10-01-06 revised November 2012 indicated: "The assessment for the use of a PASD must be completed by the interdisciplinary team prior to the implementation of the PASD.....The home shall ensure that the resident care plan states the purpose and time frame for the use of the PASD".

Documentation in Point Click Care (PCC) showed that resident #005 had a Personal Assistance Service Device (PASD) assessment completed for the use of bed rails. The assessment showed that the resident was using bed rails. The (Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment indicated that the resident used side rails. The current care plan for resident #005 did not include that resident #005 used bed rails.

Documentation in PCC for resident #001 showed the resident did not have a completed assessment for the use of bed rails and the bed rails were not included in the current plan of care.

On September 30, 2016, the Acting Director of Care #102 said that the plan of care should have set out clear directions to staff and others who provide direct care to the resident and acknowledged that the plans of care for resident #005 and #001 had not provided direction regarding the use of the bed rails for these residents. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care sets out clear directions to staff and others who provided direct care to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:

- 1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).**
- 2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).**
- 3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator worked regularly in that position on site at the home of fewer than 64 beds, at least 16 hours per week.

Mitchell Nursing Home has a capacity of 48 long-term care beds. The administrator was shared between Mitchell Nursing Home and Ritz Lutheran Villa.

On October 3, 2016, the Administrator #101 said that he did not work in the home two days per week.

On October 12, 2016, in a phone conversation, the Administrator #101 said that he worked approximately ten hours per week in the home.

The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for at least 16 hours per week. [s. 212. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Administrator works regularly in that position on site at the home of fewer than 64 beds, at least 16 hours per week, to be implemented voluntarily.



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Issued on this 20th day of October, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.