Ontario

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2018	2017_607523_0036	026903-17	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

ALI NASSER (523), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7 and 8, 2017.

The following Critical Incident Inspections were completed during this RQI:
Log #002840-17 / CI #2689-000001-17 related to a resident's fall.
Log #010098-17 / CI #2689-000003-17 related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Administrative Assistant, Activation Manager, Physiotherapist, Registered Dietitian, Housekeeping staff member, Activation staff member, seven Registered staff members, four Personal Support Workers, Residents' Council member, Family Council member, three family members and 20 residents.

During the course of the inspection, the inspector(s) toured all resident home areas. Observed medication rooms, medication administration pass and medication count, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On certain dates inspector #610 completed observations of the medication room, medication carts, medication administration, documentation for medication administration on the eMAR, signage of controlled substances by the registered staff, resident health care records for plan of care and identified areas of risk with findings of non-compliance.

The licensee policy entitled Resident Bill of Rights, policy #A-100-96, reviewed June 2018, Appendix 1 stated in part that "every resident shall have his or her personal health information (PHI) kept confidential according to the Act".

On a certain date a registered staff member told inspector #610 that they tore the top

piece of the medication package off so that the resident's name was separated from the rest of the identifiers on the packages and placed them into the garbage can on the medication cart. The PHI was not being removed prior to placement of the packaging in the garbage.

On a certain date a management team member told inspector #610 that the nursing staff were to place the medication package into a container on the nursing cart and at the end of the shift the packages were to be placed in water to remove the PHI before being placed into the garbage.

On a certain date observations of the specific medication carts showed that the pharmacy labelled medication packaging that included PHI had been placed in the garbage bin attached to the medication cart with all client identifiers still present.

Further observation was conducted with a management team member on a certain date who also observed the client identifiers on the medication packages that were placed in the garbage.

Interviews conducted in the home on certain dates with a registered staff member and a management staff member showed that the policies and procedures regarding resident Personal Health Information (PHI) were not clearly understood.

The management staff member said that the expectation was that all personal health information would be removed from the individual medication packages prior to placing the packaging in the garbage.

The license has failed to ensure that the resident's PHI was kept confidential in accordance with that Act. [s. 3. (1) 11.]

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 every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

On a certain date a progress notes in Point Click Care (PCC) showed that a resident had a significant change in status, and had become unresponsive. Cardiopulmonary resuscitation (CPR) had been initiated for the resident and Emergency Medical Services (EMS) were called. The resident was transferred by ambulance to the hospital and had deceased in hospital on the same day.

A Critical Incident System (CIS) report was first submitted to the Ministry of Health and Long-Term Care (MOHLTC) two days after the unexpected death occurred. The CIS report was further amended two days after the submission.

The licensee's policy Critical Incident Investigation and Reporting Policy #A-100-22, Revision August 2017, stated in part that the Director of Care/Designate will inform the MOHLTC immediately, in as much detail as possible in the circumstances, of each of the following incidents: an unexpected or sudden death, including death resulting from an accident or suicide.

On a certain date a management staff member acknowledged that they should have submitted a CIS report immediately to the Director, and as a result the Director was not informed until two days after the resident had deceased suddenly and unexpectedly.

On a certain date another management staff member acknowledged that they were the manager on call on the date the incident and that they had been notified of the incident. They said that they had not immediately notified the Director using the after hours call system.

The licensee has failed to ensure the Director was informed immediately following a sudden and unexpected death. [s. 107. (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 Director is informed immediately, in as much detail as possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.

Issued on this 2nd day of January, 2018

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

Original report signed by the inspector.