Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2019	2019_536745_0028	021664-19	Critical Incident System

Licensee/Titulaire de permis

Ritz Lutheran Villa
4118A Road 164 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

CHERYL MCFADDEN (745)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 15 and 20, 2019.

The inspection was completed related to:
Critical Incident (CI) log # 021664-19/CI # 2689-000010-19 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Building Services Director, Registered Nurse (RN), a Registered Practical Nurse (RPN), and Maintenance Worker.

The Inspector also made observations and reviewed health records, internal investigation records, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The home reported Critical Incident System (CIS), report to the Ministry of Long Term Care (MOLTC) on a specified date whereby, a specified resident had a significant change in their health condition.

The home's policy Responsive Behaviours #RC-201-87 with a review date of June 2019 was reviewed and stated: Procedure:

All members of the interdisciplinary team will:
1. Work together to identify possible triggers of the responsive behaviours;
2. Develop and implement strategies individualized to the resident into the care plan;
3. Evaluate the effectiveness of the plan and revise if needed;

The RN/RPN will:
1. Assess the resident exhibiting responsive behaviours and determine if the resident behaviour is endangering others;
2. Strategize with other members of the interdisciplinary team to identify the causes and triggers;
3. Refer to available resources in the health care community such as, Behavioural Support Team (BSO), Behavioural Intervention Response Team/or Psychogeriatric Resource Consultant;
4. Coach front line staff about interventions identified on the care plan and strategize them on additional interventions required.

Review of the clinical records included documentation of the residents identified

behaviours in the care plan, RAI assessments, progress notes and paper chart. Triggers, monitoring and interventions were not included in any resident documentation.

During an interview with a specific staff member, they said the identified resident was exhibiting behaviours. They also said monitoring of the resident's behaviours was not included in the notes.

During an interview with the Administrator, they said that the home needed greater direction related to the resident’s identified behaviours and the process to monitor a specified resident. They also said that the home had a specified form to document the identified behaviours that should have been initiated and was not.

During an interview with a specified staff member they said that the expectation was that when a resident exhibited behaviours, staff were to refer them to BSO so the team could complete an assessment of the behaviour and develop interventions as applicable. They also said that there had not been a BSO referral for the specified resident and should have been.

In an interview with the Director of Care (DOC), they said that the identified behaviours should have been assessed, monitoring started and documentation completed for the identified resident and it was not.

The licensee has failed to ensure that when an identified resident demonstrated responsive behaviours, that strategies were developed, that actions were taken, including assessments, and that reassessments and interventions were developed to respond to the resident’s needs and were documented. [s. 53. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, and the policy was complied with.

On a specified date the home submitted Critical Incident System (CIS) report #2689-000010-19/Log # 021664-19 to the Ministry of Long-Term Care (MOLTC) related to a significant change in the identified resident's health condition.

During an observation on a specified date, inspector #615, found that there was a maintenance issue with the identified resident's room.

A review of the home's policy #OHS-500-22 titled "Hazard Reporting" last reviewed November 2018, stated in part "Policy: To define the procedures for reporting hazardous situations or incidents and to encourage a process whereby all staff will actively recognize, evaluate and control both health and safety hazards in their own work environment. Procedure: All employees will : Correct the problem immediately (if possible), upon noticing a hazardous health or safety situation; Immediately notify and report hazardous situations or acts to the Department Supervisor, the Charge RN or Safety Committee member and lock out/tag out procedures shall be initiated in order to protect staff or residents; Fill out a Maintenance Work Requisition Form for maintenance issues that can wait for the next business day to be repaired".

During an interview a specified staff member, stated that when staff saw something in the home that was damaged, staff would report it and fill out a Work Requisition form so it could be looked at by maintenance. They also stated that they were aware of the damage, a Work Requisition form was not completed as per the home's policy and should have been.

The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was complied with. [s. 8. (1) (b)]

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 homes policy Hazard Reporting is complied with by all staff in the home, to be implemented voluntarily.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2019_536745_0028
Log No. / No de registre :	021664-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 5, 2019
Licensee / Titulaire de permis :	Ritz Lutheran Villa 4118A Road 164, R.R. #5, MITCHELL, ON, N0K-1N0
LTC Home / Foyer de SLD :	Mitchell Nursing Home 184 Napier Street, S.S. #1, MITCHELL, ON, N0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Renaud

To Ritz Lutheran Villa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 53 (4).
Specifically the licensee must:

a) identify behavioural triggers for any resident exhibiting responsive behaviours including suicidal ideation.
b) develop and implement strategies to respond to these responsive behaviours including suicidal ideation.
c) ensure actions are taken to respond to the needs of the resident include assessments, reassessments, interventions and monitoring.
d) ensure that all registered and non registered staff receive training related to the home's Suicide Assessment & Prevention Policy, revised November 2019. This includes keeping a record of staff providing the education, staff receiving the education, dates, and training content provided.
e) ensure all of a, b, c and d are documented and kept in the home.

Grounds / Motifs :

1. The home reported Critical Incident System (CIS), report #2689-000010-19 to the Ministry of Long Term Care (MOLTC) on a specified date whereby, a specified resident had a significant change in their health condition.

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endangering others;
2. Strategize with other members of the interdisciplinary team to identify the causes and triggers;
3. Refer to available resources in the health care community such as, Behavioural Support Team
(BSO), Behavioural Intervention Response Team/or Psychogeriatric Resource Consultant;
4. Coach front line staff about interventions identified on the care plan and strategize them on
additional interventions required.

Review of the clinical records included documentation of the residents identified behaviours in the care plan, RAI assessments, progress notes and paper chart. Triggers, monitoring and interventions were not included in any resident documentation.

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During an interview with a specified staff member they said that the expectation was that when a resident exhibited behaviours, staff were to refer them to BSO

so the team could complete an assessment of the behaviour and develop interventions as applicable. They also said that there had not been a BSO referral for the specified resident and should have been.

In an interview with the Director of Care (DOC), they said that the identified behaviours should have been assessed, monitoring started and documentation completed for the identified resident and it was not.

The licensee has failed to ensure that when an identified resident demonstrated responsive behaviours, that strategies were developed, that actions were taken, including assessments, and that reassessments and interventions were developed to respond to the resident's needs and were documented. [s. 53. (4)]

(745)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cheryl McFadden

Service Area Office /
Bureau régional de services : London Service Area Office