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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 19, 2022	2022_917213_0001	017360-21, 020136-21, 021181-21	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

RHONDA KUKOLY (213)

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): January 5, 6, 13, 14, 2022.

The following intakes were completed during this critical incident inspection:
Log #017360-21, a complaint related to care concerns and staffing.
Log #020136-21, a critical incident related to an incident resulting in transfer to hospital and change in condition.
Log #021181-21, a critical incident related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, Physicians, Registered Nurses, Personal Support Workers, Program Staff, a Housekeeper, and residents.

The inspector also made observations and reviewed health records, employee records, staff schedules, communications in the home and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by the staff, that resulted in harm or a risk of harm to the resident occurred, immediately reported the suspicion and the information upon which it is based to the Director.

The home submitted a critical incident report to the Ministry of Long-Term Care for an incident that occurred five days prior to the date of the report. A resident reported that they did not receive required care on an identified date and an investigation was completed related to the suspicion of neglect. The Assistant Director of Care said that the home should have reported the suspicion of neglect immediately, when it was reported to registered nursing staff and then to the management of the home.

Sources: A critical incident report, health records for a resident and staff interviews. [s. 24. (1)]

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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident, that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital, no later than one business day after the occurrence of the incident.

The home submitted a critical incident report to the Ministry of Long-Term Care for an incident that occurred approximately six months prior to the date of the report. The home was unaware of the incident until approximately five months later; but didn't report the incident to the Director until three weeks after they were notified that the incident had occurred. The Assistant Director of Care and a Physician said that the home should have reported the incident to the Director when they were notified that it occurred.

Sources: A critical incident report, health records for a resident, and staff interviews. [s. 107. (3) 4.]

Issued on this 19th day of January, 2022

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

Original report signed by the inspector.