Ontario

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

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

London District
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Original Public Report

Report Issue Date: February 2, 2023	
Inspection Number: 2023-1189-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Ritz Lutheran Villa	
Long Term Care Home and City: Mitchell Nursing Home, Mitchell	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2023.02.13 12:54:51 -05'00'
Additional Inspector(s) Rhonda Kukoly (213)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 19, 20, 23, 25, and 26, 2023.

The following intake(s) were inspected:

- Intake: #00016588 – Critical Incident #2689-000033-22, related to a fall of a resident.
- Intake: #00007807 – Critical Incident #2689-000028-22, related to the death of a resident.
- Intake: #00018319 – Critical Incident #2689-000002-23, related to a complaint/response for a resident.

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

Resident Care and Support Services
Falls Prevention and Management
Infection Prevention and Control
Reporting and Complaints

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)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
The home reported a critical incident when a resident had a fall in December 2022, and suffered an injury. Prior to this fall, the resident had a falls prevention intervention. After this fall, the home implemented a new intervention.

The resident's care plan in Point Click Care was not updated to include the new intervention, however the intervention was shown on a logo in the resident's room. During the inspection, the resident was observed without the new intervention in place.

The Assistant Director of Care (ADOC) said that the direction was not clear for staff when the care plan was not updated to show the new intervention. The ADOC revised the care plan as soon as the discrepancy was brought to their attention.

The licensee has also failed to ensure that the written plan of care for another resident set out clear directions to staff and others who provided direct care to the resident, regarding transfer assistance.

Rationale and Summary
The home reported a critical incident in January 2023, that a resident's family member had voiced multiple care concerns. One of the concerns was related to the resident's lift type for

transferring.

The resident had used specific type of lift prior to going to the hospital in December 2022. When the resident returned to the home, the hospital had reported that the resident required a different type of lift. The resident was reassessed at the home in January 2023, and was able to use the original lift type.

The logo in the resident's room indicated the original lift type. The resident's care plan in Point Click Care indicated the different type of lift from when the resident had returned from hospital.

The Assistant Director of Care (ADOC) said that the direction was not clear for staff when the logo in the resident's room indicated the original lift type, and the care plan showed a different type of lift. The ADOC revised the care plan as soon as the discrepancy was brought to their attention.

Sources: Critical Incident Reports #2689-000033-22, #2689-000032-23, health records for both residents, observations of both residents and their rooms, and staff interviews.

Date Remedy Implemented: January 23, 2023 [213]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The home reported a critical incident when a resident had fall in December 2022, and suffered an injury. Following their return from hospital, a falls management intervention was implemented. The care plan in Point Click Care related to the intervention was updated during the inspection by the Assistant Director of Care (ADOC).

During the inspection, the resident was observed in the dining room without the new falls management intervention. The ADOC said that the intervention should have been in place, but

it was not on that day at the time of the observation. The ADOC applied the intervention when it was brought to their attention.

Sources: Critical Incident Report #2689-000033-22, health records for the resident, observations of the resident and the resident's room, and staff interviews.

Date Remedy Implemented: January 26, 2023 [213]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the IPAC Lead for the home worked regularly in that position on site at the home for 17.5 hours per week as required.

Rationale and Summary
A review of the IPAC Lead's schedule showed they were working 37.5 hours each week. During an interview with the IPAC Lead, they stated that they work one shift per week in the role of IPAC Lead at Mitchell Nursing Home which amounts to seven and a half hours. They stated they also work three shifts per week in the role of Director of Care (DOC) at Mitchell Nursing Home, and one shift per week in the role of IPAC Lead at Ritz Lutheran Villa.

Sources: interview with IPAC Lead #102; and review of the IPAC Lead's schedule.

[721821]