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 prévue le Loi de 2007 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 #/ No de registre	Type of Inspection / Genre d'inspection
Oct 04, 2017;	2017_419658_0013 (A1)	016642-17	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

RITZ LUTHERAN VILLA
PART LOT 16, CON 2, LOGAN TWN R.R. #5 MITCHELL ON N0K 1N0

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

Ontario

Ministry of Health and Long-Term Care

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NEIL KIKUTA (658) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amended CO #001 and respective grounds related to an identified resident following discussion with LSAO Manager and Licensee

Issued on this 4 day of October 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

NEIL KIKUTA (658) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 31, August 1, 2, 3, 8, 9, 10, and 11, 2017.

The following intakes were completed within this Resident Quality Inspection:

Follow up log #032045-16, related to resident-staff communication and response system;

Complaint log #004667-17, IL-49596-LO, related to falls, personal support services, nutrition and hydration, and laundry;

Complaint log #005894-17, HLTC2966MC-2017-2022, related to restorative care;

Complaint log #012957-17, IL-51479-LO, related to nutrition and hydration, menu planning, and food production;

Critical Incident log #015598-16, CIS #C555-000008-16, related to alleged resident to resident abuse;

Critical Incident log #007095-16, CIS #C555-000004-16, related to falls;

Critical Incident log #019410-16, CIS #C555-000007-16, related to falls; and

Critical Incident log #022772-15, CIS #C555-000003-15, related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Building Services Director, Nutrition Services Director, Nursing Administration Schedulers, Physiotherapist, Resident Assessment Instrument Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Maintenance Worker, Dietary Aides, and Physiotherapy Assistant.

The inspectors reviewed clinical records and plans of care for relevant residents, pertinent policies, procedures, and program evaluations, and the staff schedule. Observations were also made of dining and meal service, medication administration, general maintenance, cleanliness and condition of the home, infection prevention and control practices, provision of care, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

14 WN(s)
10 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #001	2016_457630_0033	658

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. 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A. On a specified date, an identified resident told the inspector that they did not think that they used an assistive device. The identified resident acknowledged that the assistive device was in place during the time of the interview and said they thought that the device was there to assist staff.

Observations on three separate dates found the assistive device in place for the identified resident.

The clinical record for the identified resident included an admission assessment for the use of the assistive device for mobility.

Review of the Kardex, Point of Care (POC) and plan of care for the identified resident showed the assistive device was not included as an intervention.

On a specified date, an identified registered staff member told the inspector that the identified resident used the assistive device for positioning. The registered staff member reviewed the clinical record for the resident and reported there was a signed consent for the assistive device as a Personal Assistance Service Device (PASD), and said that they had been in use for the resident since admission. The registered staff member reviewed the plan of care and acknowledged that at the time of the interview the assistive device was not included as an intervention.

On a specified date, the Director of Care (DOC) told the inspector that the expectation in the home was that the plan of care would provide clear direction for staff regarding the use of assistive devices, and that this would be based on the assessment and consent for use of the PASD.

B. Multiple observations during the inspection showed that an identified resident had an assistive device in place.

Review of the care plan and Kardex in PointClickCare (PCC) documentation did not show an assistive device for the identified resident. During an interview with the resident, they stated they liked to use the assistive device. Two identified staff members stated in an interview that if a resident used an assistive device, the device would be listed in the Kardex.

On a specified date, the Director of Care (DOC) stated that the expectation was that if a resident used an assistive device, then an assessment would be completed. The DOC acknowledged that the assistive device for the identified resident had not been in the plan of care, and that the expectation was that the assistive device would be documented in the plan of care when being used.

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

A. On a specified date, a complainant shared concerns with the Ministry of Health and Long-Term Care regarding the care of an identified resident who had experienced multiple falls.

Record review of the identified resident's care plan showed that the resident was at risk for falls. Interventions included the use of a monitoring device when in bed or chair, to lower the resident's bed to the floor, and ensure a floor mat was in place.

The identified resident's online health records in PointClickCare (PCC) indicated the most recent post fall assessment was completed, and the registered nurse had documented that the resident was found on the floor in between the bed and side table, but no floor mat was in place.

On a specified date, the inspector observed the identified resident's room and noted a bed in the lowest position, a floor mat sitting against the bed, and a monitoring device with clip attached to the bed. In the dining room, the inspector observed the resident sitting in a wheelchair with no monitoring device in place.

On a specified date, an identified registered staff member stated that they had not attached the monitoring device to the identified resident when they were in the wheelchair. The registered staff member reviewed the resident's Kardex in Point of Care (POC) and acknowledged that the monitoring device should have been in place.

On a specified date, the Director of Care (DOC) acknowledged that a floor mat was not in place during the identified resident's most recent fall, and that the monitoring device was not in place during observations. The DOC explained that the resident was at moderate risk for falls, and stated that they expected the floor mat and monitoring device to be in place as they were a part of the resident's plan of care.

B. On a specified date, an identified resident told the inspector that they were regularly seeing the dentist, and that the dentist had requested oral care to be completed three times daily. The resident told another inspector that they wanted assistance from staff to utilize an assistive device after each meal for oral care.

Record review of progress notes in PointClickCare (PCC) showed that the identified resident had returned from a dental appointment on a specified date, and the dentist had provided instructions to utilize the assistive device and brush teeth after each meal.

Review of the online care plan indicated that the Resident Assessment Instrument (RAI) Coordinator revised two interventions to encourage the identified resident to complete oral care and to use the assistive device after each meal.

On a specified date, an identified staff member stated that they had not provided the identified resident oral care after breakfast because the resident did not ask for

it to be completed. The staff member said that they had never used the assistive device for oral care, and was never told to use it for the resident.

On a specified date, the Director of Care (DOC) acknowledged that the identified resident did not receive the appropriate oral care as indicated in the resident's plan of care. The DOC expected that the resident would have their teeth brushed and assistive device utilized after each meal.

C. On a specified date, a complainant shared concerns with the Ministry of Health and Long-Term Care regarding the oral care of an identified resident.

Progress notes in PointClickCare (PCC) showed that the Director of Care (DOC) had documented a family concern related to the care of the identified resident. The note stated that staff would encourage/provide mouth care after each meal.

Review of the identified resident's care plan showed an intervention was implemented to provide mouth care after each meal.

On a specified date, a staff member stated that they had not provided the identified resident oral care after breakfast. The staff member reviewed the Kardex in POC and acknowledged that oral care was to be provided after every meal.

On a specified date, the DOC acknowledged that the identified resident required oral care after each meal as per the plan of care.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Record review of PointClickCare (PCC) showed an initial admission assessment progress note which documented that an identified resident liked to go to bed around 2300 hours, and wake up around 0700-0730 hours. There was no other documentation regarding preferences for sleep and wake times in the care plan or Kardex.

On a specified date, an identified staff member stated that the identified resident did not like to get up early unless they were ringing for assistance. If staff went in around 0700 hours, the resident would tell staff it was too early and not to get them

up.

Another identified staff member stated that the identified resident usually rang when they were ready for staff to get them up, and liked to sleep longer in the morning. The staff member stated that the residents' preferences should be in the Kardex, and acknowledged that they were not present when viewed with the inspector.

On a specified date, the Director of Care (DOC) stated that if a preference was not listed in the plan of care then the resident would be on the routine of the home area. The DOC acknowledged that there were no sleep preferences on the care plan and stated that the care plan should at least say that the identified resident would ring when ready to get up in the morning.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed regarding sleep preferences.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of related noncompliance in the last three years as evidenced by a WN and VPC being issued in inspection report #2014_303563_0026 on August 18, 2014, WN being issued in inspection report #2015_260521_0045 on September 28, 2015, WN and VPC being issued in inspection report #2016_325568_0003 on February 9, 2016, and a WN and VPC being issued in inspection report #2016_457630_0033 on September 20, 2016. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 a written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident; to ensure that the care set out in the plan of care was provided to the resident as specified in the plan; and to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Ontario Regulation 79/10 defines sexual abuse as (a) "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, subject to the following exclusions: (i) touching, behaviour or remarks of clinical nature that are appropriate to care provision or assistance with activities of daily living or (ii) consensual touching, behaviour or remarks of a sexual nature in the course of a sexual relationship that began before the resident was admitted to the

home or before the licensee/staff member became a licensee/staff member, or (b) any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC). This report showed that on a specified date, there was an incident where an identified resident was pursuing a cognitively-impaired resident.

On a specified date, the family member of the cognitively-impaired resident recalled the incident and said that the identified resident still pursued the cognitively-impaired resident after moving them to another floor.

On a specified date, an identified staff member said that they had observed the two residents holding hands but nothing more. The staff member said that one of the residents was capable of understanding their behaviours, while the other resident was not. The staff member clarified that the resident who was capable of understanding their behaviours had been moved to another area of the home to try to keep the two separated. The staff member stated that kissing between a resident who was not cognitively able to consent, and one who was able, such as between the two identified residents, would need to be reported to management as they considered this to potentially be sexual abuse. The staff member said it was their understanding that kissing was not allowed between residents who were not cognitively able to consent.

Review of the clinical record for the identified residents found the following documentation:

- A progress note on a specified date stated the identified resident had their arm around the cognitively-impaired resident.

- A progress note on a specified date stated the identified resident was observed speaking with the cognitively-impaired resident, holding hands, and kissing. The identified residents were separated, and the cognitively-aware resident was informed that such behaviour was not allowed.

- A progress note on a specified date stated that the two identified residents were observed kissing.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect with current revision in March 2016 stated that "All Staff" were to "protect, detect and immediately respond to any alleged or suspected incidents of resident abuse or neglect." This policy also stated that the "Administrator or Designate or Department Manager Supervisor" were to "promote fulsome and timely internal and external reporting and disclosure."

On a specified date, the inspector reviewed the CIS report with the Director of Care (DOC). The DOC acknowledged that they notified the MOHLTC of this alleged resident to resident abuse two days after it was reported. The DOC said they had been aware of previous issues involving intimacy between these two residents as they had been found by staff kissing, and the family of the cognitively-impaired resident was not in agreement with that behaviour. The DOC said that kissing between a resident who was unable to consent to sexual touching and behaviours from another resident, such as between the two identified residents, could be considered sexual abuse and it was the expectation within the home that abuse would immediately be reported to the MOHLTC. The DOC said it was the expectation that staff in the home would follow the home's policy on the prevention of resident abuse and this included reporting alleged incidents of abuse to management.

On a specified date, the Administrator said they had been involved with the issue and that on a previous date had come up with a letter that they gave to the cognitively-aware resident with restrictions and interventions to help minimize the potential for interaction. The Administrator said that they did not consider the incident between the two identified residents to be sexual abuse, but the CIS report was submitted to the MOHLTC anyways.

Based on these interviews and record reviews the licensee failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. The interviews and record reviews showed that the staff and management in the home failed to protect, detect, and immediately respond to any alleged or suspected incidents of resident to resident sexual abuse or neglect. The interviews and record reviews also showed that the management in the home did not "promote fulsome and timely internal and external reporting and disclosure" of the alleged sexual abuse from the cognitively-aware resident towards the cognitively-impaired resident.

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained the following as outlined in the Act:
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; and
(f) shall set out the consequences for those who abuse or neglect residents

Long-Term Care Homes Act, 2007, c. 8, s. 24 (1) states:
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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006
Under the Act, the Director means the person appointed under section 175 as the Director.

Review of Ritz Lutheran Villa policy #RC-201-02 titled Abuse and Neglect (Zero Tolerance), last revised on October 2016, stated in part that all staff:
"1. Protect, detect and immediately respond to any alleged incident or suspected incident of resident abuse or neglect.
2. Ensure the safety and comfort of the victim."
The policy did not address how to report the incident, who to report the incident to, or the consequences for those who abused or neglected residents. The policy stated "At minimum the following information will be available: consequences for abusing/neglecting a resident or failing to report it."

On a specified date, the Administrator stated that the Abuse and Neglect (Zero Tolerance) policy #RC-201-02 with a revised date of October 2016, was the current policy. The Administrator reviewed the policy with the inspector and acknowledged that it did not provide direction for staff regarding how and when to report alleged incidents of abuse. The Administrator stated that the staff all knew how and when to report, and the staff had been educated on using the complaints form process.

The Administrator stated they had disclosure guidelines in policy #RC-201-30 with a revised date of October 2016, which provided direction for staff. The Administrator clarified that this policy was not referenced or linked to the Abuse and Neglect policy #RC-201-02, and that they were planning to fix the prevention of abuse policy as the policy should provide direction for staff.

On a specified date, the Director of Care (DOC) reviewed the Abuse and Neglect (Zero Tolerance) policy #RC-201-02, and acknowledged that the policy did not give clear direction for all staff to follow on how and when to report incidents of abuse, or reference mandatory reporting. The DOC also acknowledged that the policy did not direct staff to immediately report, and that the procedures to direct front line staff in a situation of abuse were not in the policy.

On a specified date, the Administrator acknowledged that the policy lacked procedural information for staff to follow. The Administrator stated that they were working on a new policy and once completed they would need to educate staff on the policy. The Administrator acknowledged that other policies were not referred to in the current Abuse and Neglect policy.

The scope of this area of non-compliance was determined to be widespread. The severity was determined to be a level two, related to potential for actual harm. There was a history of related noncompliance in the last three years as evidenced by a WN being issued in inspection report #2015_260521_0045 on September 28, 2015.

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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, and that the policy to promote zero tolerance of abuse and neglect of residents contained all requirements as outlined in the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 when a person had reasonable grounds to suspect that abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC). This report showed that on a specified date, there was an incident where a cognitively-aware resident pursued a cognitively-impaired resident and engaged in physical contact.

On a specified date, the inspector reviewed the CIS report with the Director of Care (DOC). The DOC acknowledged that they notified the MOHLTC of this alleged resident to resident abuse two days after it was reported. The DOC said they had been aware of previous issues involving intimacy between these two residents as they had been found kissing by staff. The DOC said that one of the identified residents had cognitive impairment and had no understanding of what was happening, while the other identified resident was of a different cognitive status and "knew what they were doing". The DOC said that kissing between a resident who was unable to consent to sexual touching and behaviours from another resident, such as between the two identified residents, could be considered sexual abuse and it was the expectation within the home that abuse would immediately be reported to the MOHLTC.

On a specified date, the Administrator said that they did not consider the incident between the two identified residents to be sexual abuse but the CIS report was submitted to the MOHLTC anyways and that in their opinion it was done in a timely manner.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 a person who had reasonable grounds to suspect that abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

On a specified date, an identified resident told the inspector that they preferred to go to bed at 2200 hours and at times staff would not assist them to bed until 2100 hours. The identified resident also said that they would prefer to get up at 0600 hours, but since being admitted to the home they had been getting up between 0700 hours and 0800 hours. The identified resident said that they would sometimes ring their call bell in the morning to get up and at times had to wait about an hour before staff responded.

On a specified date, an identified staff member told the inspector that they would look in the Kardex in PointClickCare (PCC) to determine the care needs of the residents. The staff member said that from their knowledge, the identified resident did not have a specific time that they preferred to get up or go to bed. The staff member looked in the Kardex for the resident and acknowledged there was no direction in terms of when the resident preferred to go to bed or to get up.

Further review of the clinical record for the identified resident found no assessment of sleep pattern or preferences documented at or since admission. Review of the plan of care, Kardex and POC identified that sleep pattern and preferences were not included.

On a specified date, the Director of Care (DOC) said it was the expectation in the home that sleep preferences and patterns would be assessed at admission and on an ongoing basis for residents. The DOC also said it was the expectation that the plan of care would include direction for staff regarding a resident's sleep preferences.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 a plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs, and that met the requirements set out in the Act and the Regulation.

Ritz Lutheran Villa Contingency Plan to Address Staffing & Budgetary Issues with an effective date of February, 2017, stated in part the following for a normal staffing pattern:
- One registered nurse during the day (12 hour shift), one registered nurse during the night (12 hour shift);
- Four registered practical nurses during the day (two per unit), four registered practical nurses during the evening (two per unit), one registered practical nurse during the night (second floor); and
- Eight personal support workers during the day (four per unit), eight personal support workers during the evening (four per unit), four personal support workers during the night (two per unit).

The plan stated that if fully staffed, the first sick call of any shift would not be replaced for registered practical nurses or personal support workers.

During stage one of the inspection, nine of 19 interviewable residents voiced concerns related to sufficient staffing in the home. These concerns were related to waiting extended periods of time for care and assistance, where seven of the nine complaints were specific to toileting.

One of the complaints came from an identified resident who expressed to the inspector that they would often have to sit on the toilet for up to an hour, and the average wait time was close to 30 minutes. Progress notes in PointClickCare (PCC) showed multiple documented accounts of the identified resident complaining of being left on the toilet for prolonged periods of time. The identified resident's care plan indicated that the resident would ask for and receive the necessary assistance related to toileting, and required one person assistance for toileting needs.

The inspector reviewed a three month call bell audit, where the identified resident's call bell rang for over 20 minutes on 52 different occasions.

Another complaint came from a different identified resident, who reported having to wait over half an hour for staff to assist with toileting and sometimes it would be very uncomfortable to wait that long.

On a specified date, the identified resident expressed that they required one person assistance with transfers to the toilet, and was capable of ringing the call bell for assistance. The identified resident said that there were long waits every day

from 15 to 30 minutes, and that it was worse right after meals. After the interview, the identified resident rang the call bell for toileting assistance, and it was not until approximately 15 minutes later that a personal support worker answered the call bell. During the approximately 15 minutes, personal support workers were observed in the hallway moving residents out of the dining room after breakfast. Staff were walking past the door and not responding to the call bell. This observation was completed when the day shift floor was fully staffed with two RPNs and four PSWs.

On a specified date, observations were completed on the second floor during morning care. The inspector noted a full complement of staff, consisting of two RPNs, and four PSWs. During the observation, one call bell rang at 0708 hours and rang for approximately 27 minutes before being answered by a personal support worker.

On a specified date, the Administrator explained that it was their expectation that call bells would be answered within three minutes, and that call bells should not be going off for extended periods of time.

The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs as evidenced by interviews, observations, and record review of prolonged call bell response times.

2. The licensee has failed to ensure that the staffing plan included a back-up plan for registered nurses that addressed situations when staff could not come to work.

Review of the Contingency Plan to Address Staffing & Budgetary Issues with an effective date of February 2017, outlined the requirement of a registered nurse working 12 hour shifts during the day and night. The reassignment protocol addressed what to do when a personal support worker or registered practical nurse was missing, but did not address the steps to take when a registered nurse was unable to come to work.

On a specified date, the Administrator acknowledged that this information was missing from the staffing and contingency plan, and that it should be added.

The scope of this area of non-compliance was determined to be widespread. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin

integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a specified date, an identified staff member told the inspector that an identified resident had an area of altered skin integrity. The identified staff member said that the altered skin integrity had existed for several months but was slowly healing, and that all reported areas of altered skin integrity were to be initially assessed by the registered staff using an assessment form in PointClickCare (PCC).

Review of the clinical record for the identified resident showed that they had developed an area of altered skin integrity, and the first "Weekly Wound Care Assessment Record" in PCC for the area of altered skin integrity was completed seven days later.

On a specified date, the DOC said that it was the expectation in the home that registered staff would complete an initial wound assessment for any newly reported areas of altered skin integrity on the day it was identified. The DOC said that the assessment would be completed using the "Weekly Wound Care Assessment Record."

On a specified date, the DOC told the inspector that they had reviewed the chart for the identified resident and acknowledged that the initial wound assessment for the area of altered skin integrity was not completed on the day that it had been reported to the registered staff.

2. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Multiple observations during the inspection found that an identified resident had a pressure relief device in place for altered skin integrity.

On a specified date, an identified staff member told the inspector that the identified resident had an area of altered skin integrity. The staff member said that all areas of altered skin integrity were to be assessed by the registered staff weekly using an assessment form in PCC based on the alert in the electronic Treatment Administration Record (eTAR).

Review of the clinical record showed that the identified resident did not have a "Weekly Wound Care Assessment Record" completed for nine weeks in a 24 week period (38 per cent).

On a specified date, the DOC said that it was the expectation in the home that registered staff would complete a weekly wound re-assessment for the identified resident's altered skin integrity using the "Weekly Wound Care Assessment Record." The DOC said that they had completed audits of the weekly wound assessments completed for the resident's altered skin integrity, and acknowledged that there were weekly wound reassessments that had not been completed.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of related noncompliance in the last three years as evidenced by a WN and VPC being issued in inspection report #2016_457630_0033 on September 20, 2016.

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 a resident exhibiting altered skin integrity, including pressure ulcers, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; and to ensure that a resident who was exhibiting altered skin integrity, including pressure ulcers, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with personal assistance and encouragement required to safely drink as comfortably and independently as possible.

On a specified date, a complainant shared concerns with the Ministry of Health and Long-Term Care regarding the snack service and provision of assistance for an identified resident.

During the entrance conference with the Director of Care (DOC), it was determined that scheduled snack times occurred at 1030 hours, 1415 hours, and 1930 hours.

Review of the identified resident's care plan outlined that they were at high nutritional risk due to requiring some feeding assistance, and recent low fluid intakes.

On a specified date, the inspector observed the identified resident sitting in the dining room during breakfast. The resident was seen eating and drinking independently at times, and requiring encouragement from staff at other times. Prior to lunch, the inspector noted a three quarter full orange juice cup on the resident's side table. The resident was sitting in the room, but not attempting to go over to the side table and drink the juice. After lunch, the orange juice remained on the side table at the same level.

On a specified date prior to lunch, the inspector observed a full cup of apple juice on the identified resident's side table. After some time a family member entered the

resident's room and assisted them to drink the juice.

On another specified date prior to lunch, the inspector observed an identified staff member distributing drinks from the snack cart to the identified resident in the hallway. The inspector saw the staff member offer the resident a drink then took the orange juice and placed it onto the side table in the resident's room. The staff member acknowledged that they had not sat with the resident to finish the orange juice, and had instead left it on the resident's side table. The staff member explained that if given more time, staff would try and sit with the residents, but also that the resident would not seek out the drink on their own. At lunch time, the orange juice sitting on the resident's side table remained full.

On a specified date, the Director of Nutrition Services stated that if a resident required encouragement or physical assistance with drinks during snack service, that a Personal Support Worker (PSW) other than the one serving the drinks would provide the necessary assistance. If there was no help available, then the PSW serving the drinks would be expected to stay with the resident and provide assistance. The Director of Nutrition Services explained that it was inappropriate to leave the drink at the side table then leave, and that they expected staff to sit with and feed the identified resident their drink.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 residents were provided with personal assistance and encouragement required to safely drink as comfortably and independently as possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged abuse that the licensee suspected may constitute a criminal offence.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date that outlined an incident where a cognitively-aware resident pursued a cognitively-impaired resident and engaged in physical contact.

On a specified date, the Director of Care (DOC) acknowledged that they did not notify the police of the alleged abuse between the two identified residents. The DOC said it was the expectation in the home to notify the police of incidents of alleged abuse.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 appropriate police force was immediately notified of any alleged abuse that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On a specified date, the inspector observed a bottle of lactulose left open and on top of the medication cart outside of the dining room. The nurse was inside the dining room administering medications and away from the cart. An identified registered staff member stated that the expectation was that the lactulose would be placed back in the medication cart and kept locked when away from the cart.

On another specified date, the inspector observed a bottle of lactulose left open and on top of the medication cart outside of the dining room. The nurse was not present at the medication cart and was in the dining room administering medications. The second nurse stationed at the medication cart area was also in the dining room administering medications and away from the cart. An identified registered staff member stated that all medications were to placed inside the medication cart when registered staff left the cart.

On a specified date, the Director of Care (DOC) stated that the expectation was that the lactulose would be closed and locked in the medication cart when the staff member was away from the cart. The DOC acknowledged that lactulose was a medication and was administered by registered staff using the electronic medication administration record.

The licensee has failed to ensure that lactulose had been secured and locked in the medication cart during a medication pass when the registered staff were not present at the cart.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 drugs were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On a specified date, an inspector noted that the door to the nursing station on first floor was propped open with a hole punch, and the medication cart located directly inside the nursing station was unlocked. An identified registered staff member acknowledged that the door and medication cart were left unlocked, and stated that they had left to give a medication to a resident and then assisted another staff member before returning. The registered staff member stated the expectation was that the medication cart and door to the nursing station would be locked at all times.

On another specified date, an inspector observed that the first floor medication cart was unlocked in the nursing station. The nursing station door was locked, but the room was accessible to all staff with the code to the room, including personal support workers. The Director of Care (DOC) was alerted to the medication cart being left unlocked and acknowledged that the cart was unlocked.

The DOC stated that the expectation was that the door to the nursing station and the medication cart would be locked at all times. The DOC stated that this home area had residents who wandered and that the nurses were aware that the door to the nursing station and the medication cart should be locked at all times.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

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 all areas where drugs were stored were kept locked at all times, to be implemented voluntarily.

WN #11: 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 :

1. The licensee has failed to ensure that for each resident demonstrating behaviours, the behavioural triggers for the resident were identified.

Review of an identified resident’s care plan showed that the resident exhibited behaviours of sexual nature, and staff were to distract the resident with other activities.

Behavioural Supports Ontario (BSO) progress notes in PointClickCare (PCC) showed that the identified resident was added to the BSO caseload after exhibiting behaviours towards other residents. The identified resident would often hold hands with another resident, and the resident assumed that other residents were their spouse.

On a specified date, an identified staff member explained how the identified resident’s behaviours were triggered by residents of the opposite sex with a particular colour of hair because they resembled their spouse. Staff were instructed to separate the residents whenever this behaviour was exhibited, and eventually the behaviour disappeared. An action plan was created when the identified resident exhibited these behaviours, and provided instruction on how to react when the resident was exhibiting sexual behaviours. When the identified resident was exhibiting these behaviours, the action plan and care plan did not identify the trigger of the behaviour, and the identified staff member acknowledged that this was not captured in the resident’s plan of care.

On a specified date, the Director of Care (DOC) said that they expected the identified resident’s behavioural trigger to be identified in the plan of care.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was no history of related non-compliance in the last three years.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrence.

On a specified date, the Director of Care (DOC) stated that the annual evaluation of the zero tolerance of abuse and neglect policy would be covered in a continuous quality improvement (CQI) meeting, and that it would be in the CQI binder if it was there. The DOC stated that they would not know where else it would be, and was not sure whether there was a record kept of the program review.

Record review of a document from the CQI binder titled "Quality Protocol Prevention of Abuse, neglect and retaliation," did not contain any information regarding changes or improvements that were required to prevent further occurrence. On a specified date, the inspector reviewed this with the DOC, who stated that the document was not an annual review, but rather a quality protocol that was done as part of the annual review. The DOC stated that they had not completed an annual review this year, and was unable to locate one for the 2016 calendar year.

On a specified date, the Administrator stated that an annual review had not yet been completed for the 2017 calendar year, but that if there was an annual review it would have been in the annual review binder. The DOC was unable to locate the zero tolerance of abuse and neglect annual review.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level one, related to minimum. There was no history of related non-compliance in the last three years.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home for the complaint submitted by an identified resident regarding rough handling during care.

On a specified date, an identified resident stated that they had been treated roughly during care, and that they had reported the staff member after the incident to the Director of Care (DOC) and Administrator. The resident stated that they did not want the staff member to care for them further due to the incident. On a specified date, the resident stated that the staff member was rough, and that the staff member was no longer providing care for the resident.

On a specified date, the DOC stated that a complaint had come forward but did not believe that it was this issue. The DOC explained that if there was a complaint, a complaint log would have been filled out. The DOC reviewed the 2016 complaints and was unable to find a complaint log with the identified resident in regards to the incident of rough handling, and stated that they did not have any recollection of this incident.

On a specified date, the Administrator stated that they did not recall being notified of this incident and stated that they see all of the complaints submitted.

On a specified date, an identified staff member stated that they felt the incident occurred over a year ago, but remembered the incident. The staff member stated they were working a night shift and it was during morning care, and explained that the resident felt that a personal support worker (PSW) was rough during care. The staff member stated they had written it down on a piece of paper and left it for the DOC. The staff member explained that the PSW had followed up with them and stated that the DOC had spoken to them about the incident.

On a specified date, the identified PSW stated that another identified staff member had told them they could not do care for the identified resident. The PSW said that they talked to the DOC, and that it was decided that the PSW would not care for the resident.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level one, related to minimum risk. There was no history of related non-compliance in the last three years.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision maker, the resident's attending physician, and the pharmacy service provider.

During the inspection, medication incidents for a three month period were reviewed.

Record review showed that four medication incident reports contained no documentation to support that the resident's families had been notified of the incidents. There were three medication incident reports with no documentation to support that the attending physician had been notified of the incident, and one medication incident report was not sent to the pharmacy service provider. The medication incident reports that had the missing notifications were medications errors that had involved the resident.

On a specified date the Director of Care (DOC) acknowledged that the notifications had not been completed. The DOC stated that the expectation was that all notifications would be completed for medication incidents that involved a resident.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level one, related to minimum risk. There was no history of related non-compliance in the last three years.

Issued on this 4 day of October 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NEIL KIKUTA (658) - (A1)

Inspection No. / No de l'inspection : 2017_419658_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 016642-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 04, 2017;(A1)

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Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

To RITZ LUTHERAN VILLA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
This licensee will ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

The licensee will also specifically ensure that two identified resident's plan of care sets out clear directions related to the use of assistive devices.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A. On a specified date, an identified resident told the inspector that they did not think that they used an assistive device. The identified resident acknowledged that the assistive device was in place during the time of the interview and said they thought that the device was there to assist staff.

Observations on three separate dates found the assistive device in place for the identified resident.

The clinical record for the identified resident included an admission assessment for the use of the assistive device for mobility.

Review of the Kardex, Point of Care (POC) and plan of care for the identified resident showed the assistive device was not included as an intervention.

On a specified date, an identified registered staff member told the inspector that the identified resident used the assistive device for positioning. The registered staff member reviewed the clinical record for the resident and reported there was a signed consent for the assistive device as a Personal Assistance Service Device (PASD), and said that they had been in use for the resident since admission. The registered staff member reviewed the plan of care and acknowledged that at the time of the interview the assistive device was not included as an intervention.

On a specified date, the Director of Care (DOC) told the inspector that the expectation in the home was that the plan of care would provide clear direction for staff regarding the use of assistive devices, and that this would be based on the assessment and consent for use of the PASD.

B. Multiple observations during the inspection showed that an identified resident had an assistive device in place.

Review of the care plan and Kardex in PointClickCare (PCC) documentation did not show an assistive device for the identified resident. During an interview with the resident, they stated they liked to use the assistive device. Two identified staff members stated in an interview that if a resident used an assistive device, the device would be listed in the Kardex.

On a specified date, the Director of Care (DOC) stated that the expectation was that if a resident used an assistive device, then an assessment would be completed. The DOC acknowledged that the assistive device for the identified resident had not been in the plan of care, and that the expectation was that the assistive device would be documented in the plan of care when being used.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of related noncompliance in the last three years as evidenced by a WN

and VPC being issued in inspection report #2014_303563_0026 on August 18, 2014, WN being issued in inspection report #2015_260521_0045 on September 28, 2015, WN and VPC being issued in inspection report #2016_325568_0003 on February 9, 2016, and a WN and VPC being issued in inspection report #2016_457630_0033 on September 20, 2016.
(630)

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

Sep 15, 2017

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 Health and 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

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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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 4 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NEIL KIKUTA - (A1)

Ontario

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Service Area Office / Bureau régional de services : London