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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 9, 2024

Inspection Number: 2024-1504-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Ritz Lutheran Villa

Long Term Care Home and City: West Perth Village, Mitchell

Lead Inspector	**Inspector Digital Signature**
Cheryl McFadden (745)	Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2024.05.27 08:48:05 -04'00'

Additional Inspector(s)
Kristen Murray (731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 10, 11, 12, 15, 16, 18, 2024

The following intake(s) were inspected:

- Intake: #00104569 - 3007-000092-23 related to resident to resident abuse
- Intake: #00109592 - 3007-000025-24 related to falls management
- Intake: #00111766 - 3007-000037-24 related to resident to resident abuse
- Intake: #00113263 - complaint related to prevention of abuse and neglect
- Intake: #00113532 - 3007-000044-24 related to prevention of abuse and neglect

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The following intakes were also completed in this inspection:
- Intake: #00107347 - 3007-000013-24 related to falls management

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

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

Rationale and Summary

A Complaint was received by the Director regarding the care and services of a resident.

In a review of the home's complaint response forms, the home had received a complaint from the Power of Attorney (POA) of an identified resident, stating the

resident had been improperly cared for on several occasions.

Review of evidence identified several staff members not completing resident care in accordance with the resident's plan of care.

The Director of Care (DOC) and Chief Executive Officer (CEO) confirmed the plan of care had not been followed on several occasions.

There was a low risk to the resident as a result of staff not completing resident care in accordance with the resident's plan of care.

Sources: Formal complaint form from POA of a resident, Clinical records, including care plan, and video review, Interviews with DOC and CEO. [745]

WRITTEN NOTIFICATION: Plan of Care (Reassessment, revision required)
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident's care needs changed or the care set out in the plan was no longer necessary the plan of care was reviewed and revised.

Rationale and Summary

A resident was admitted to the home and when their care needs changed, the resident's care plan was not updated to reflect a change in their needs.

The Director of Care (DOC) acknowledged that the resident's care plan should have been updated to reflect their changed care needs.

There was low risk to the resident related to their care plan not being revised when their care needs changed.

Sources: Clinical records for a resident, including the care plan, progress notes, and the eTAR; and Interviews with DOC. [731]

WRITTEN NOTIFICATION: Safe Lifts and Transfers

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
NC with O. Reg 246/22 s.40 to safe lifts and transfers.

The licensee failed to ensure that staff used safe transferring techniques when using transferring a resident.

Rationale and Summary

The home submitted a Critical Incident System (CIS) report, as it was reported to the home that improper care had been provided to a resident.

Review of evidence identified different staff members completing improper care. Review of the resident's care plan included the proper care required for the resident.

The home's Policy included the proper care procedure to be followed.

Personal Support Worker (PSW), Director of Care (DOC) and Chief Executive Officer (CEO) stated a resident was cared for improperly on several occasions.

Sources: Clinical records for a resident, including care plan, The home's investigation documentation, including video review, the home's Policy and Interview's with PSW, DOC and CEO. [745]

WRITTEN NOTIFICATION: Required Programs (Falls)

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the "Falls Prevention & Management policy", number RC-201-49, last revised February 2024, was complied with as a part of the Falls Prevention and Management Program.

Rationale and Summary

A resident sustained falls on numerous dates. The HIR documentation for the resident had sections where the level of consciousness of the resident was identified as "sleeping" or was incomplete.

Another resident sustained a witnessed fall. No HIR was completed for the resident related to the fall.

The home's falls prevention and management policy identified that if a resident had sustained a fall, registered staff were to initiate HIR if the resident fall was unwitnessed or a head injury was suspected, and monitor neurological status post-fall for signs of neurological changes, including assessing level of consciousness, vital signs, and pupillary reaction at specific intervals after the fall.

A Registered Nurse (RN) stated that HIR was completed after any unwitnessed fall or if the resident hits their head, and the expectation was that the resident was woken up if they were sleeping to complete the HIR to check pupil reaction. The Director of Care (DOC) acknowledged that sections of the HIR should not be blank, and should not state the resident was sleeping. DOC acknowledged that HIR was not completed appropriately for multiple falls of a resident on identified dates.

There was increased risk to the resident related to HIR being incomplete for multiple falls that the resident sustained.

Sources: The home's falls policy "Fall Prevention & Management", Clinical records for a resident including progress notes, assessments, and the paper chart; and Interviews with RN and DOC [731]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument, specifically designed for falls.

Rationale and Summary

A resident's progress notes identified they had sustained falls on multiple occasions and no post-fall assessments were completed for the resident related to the falls.

The home's falls prevention management policy included registered staff should have completed a post fall assessment, including assessing the environment for contributing factors of the fall. In an interview with a Registered Nurse (RN) they stated that post-fall assessments should have been completed after each resident fall. In an interview with the Director of Care (DOC) they acknowledged that staff should have completed a post-fall assessment when the resident sustained falls.

There was increased risk to the resident related to not having post-fall assessments completed after two of their falls.

Sources: The home's falls policy "Fall Prevention & Management", Clinical records for a resident, including progress notes, and assessments; and Interviews with RN, and DOC. [731]

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically the Licensee shall

-reeducate all staff that are employed by the home, related to prevention of abuse and neglect.

-keep onsite and readily available all records related to the education including who completed the education, the date the education was completed, who provided the education and the content of the education.

Grounds

NC with FLTCA, 2021, s. 24 (1) Duty to protect

24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse from staff members.
Ontario Regulation 246/22 s. 2. (1) (a) defines "emotional abuse" as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Ontario Regulation 246/22 s. 2. (1) (a) defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
The home submitted Critical Incident System (CIS), as it had been reported to the home that there was rough, improper care provided by staff to a resident.
Review of the home's investigation file showed that a Power of Attorney (POA) reported to the home that they had evidence of multiple staff members being rough and providing improper personal care to a resident.

Review of a resident plan of care confirmed the resident required assistance for care.

An Inspector reviewed the evidence and identified the resident being ignored and receiving rough and improper care by staff.

The home's policy related to prevention of abuse and neglect stated, Abuse: in relation to a resident means physical, sexual, emotional, verbal or financial abuse, including pulling, rough handling, pushing and ignoring resident.

The Director of Care (DOC) stated they were aware of the complaint related to improper care of a resident and the home had initiated an immediate investigation.

The Chief Executive Officer (CEO) shared that once the home became aware of the concern, they immediately investigated and multiple staff members provided improper care to a resident and corrective actions were taken.

The licensee's failure to protect a resident from abuse and improper care had negatively impacted the resident.

Sources: Review of the home's investigation file, video review, a resident plan of care, interviews with DOC, CEO and the home's polices related to prevention of abuse and neglect. [745]
This order must be complied with by June 20, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

There was one Directors Order with LTCHA, 2007 s. 19 (1), issued for the CIS inspection #2021_886630_0019 on July 14, 2021.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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