Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 22, 23, 24, 25, 29, Jun 6, 27, Jul 6, 2012	2012_092203_0012	Critical Incident

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

CARMEN PRIESTER (203)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Restorative Care Coordinator, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the clinical record, observed resident care, interviewed staff, reviewed specific policies and procedures related to Falls Prevention. The Log# for this inspection is L-000694-12 and was carried out in conjunction with the Resident Quality Inspection L-000691-12

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The interdisciplinary team that meets to discuss falls in the home did not discuss the identified resident after any of the falls.
The Restorative Coordinator confirmed that interventions for the identified resident were not discussed.
[LTCHA 2007,s.o.2007,c.8,s.6(4)(a)]
2. Record review confirms that the identified resident had a change in health status. This is not addressed in the plan of care.
The identified resident's unmanaged pain is not addressed in the plan of care.
The identified resident's plan of care was last reviewed March 30, 2012 and the resident had a significant change in health status after that date.
The identified resident's plan of care does not address interventions to be implemented as a result of a previous exposure to an infection. [LTCHA, 2007,s.o.2007,c.8,s.6(10)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with legislation that the licensee shall ensure that the staff and others involved in the care of the resident shall collaborate with each other in the assessment of the resident and the development and implementation of the plan of care., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The DOC confirmed that the expectation of the Home is that a post fall assessment will be completed following every fall.
2. An identified resident sustained 8 falls in the last 6 months. A clinical record review confirms that a post falls assessment was not completed for 6 out of 8 falls.
A clinically appropriate assessment instrument that is specifically designed for falls was not used. [O.Reg 79/10,s.49(2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

An identified resident's care plan states "place in falls Prevention program", created on March 26, 2012. The meetings held April 12 and may 17 do not address the resident's falls.
DOC confirms that the falls Prevention Program has only started in the last two months
A Registered staff stated that the falls Prevention Program had only started in the last month.
[O. Reg79/10,s.8(1)(b)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Regulation requires the licensee to institute or put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 6th day of July, 2012

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