



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Mar 12, 2013, 2013_182128_0006, L-000133-13, Complaint

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

RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 6 & 7, 2013

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Acting Director of Care, Assistant Director of Care, 3 Registered Practical Nurses and 1 Physician.

During the course of the inspection, the inspector(s) reviewed complaint records and procedures, observed grooming and hygiene of residents and reviewed the clinical record for an identified resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention



Personal Support Services
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. Legend includes WN (Written Notification), VPC (Voluntary Plan of Correction), DR (Director Referral), CO (Compliance Order), WAO (Work and Activity Order). Legendé includes Avis écrit, Plan de redressement volontaire, Aiguillage au directeur, Ordre de conformité, Ordres : travaux et activités. The table also contains text describing non-compliance with LTCHA requirements and the corresponding written notification under paragraph 1 of section 152.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints



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Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Two documented written complaints concerning an identified resident's care were received by the home, but were not forwarded to the Director, as required. The Administrator acknowledged that neither of the complaints were forwarded to the Ministry. [s. 22. (1)]

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 complaint procedures are revised to meet the LTCHA, including forwarding required submissions to the Ministry, to be implemented voluntarily.

WN #2: 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 :



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1. There is no documented evidence to support that strategies were developed and implemented to respond to an identified resident's responsive behaviours, despite the need being identified in the admission assessment.

The Acting Director of Care and Assistant Director of Care both acknowledged that interventions were not implemented despite the assessed need being identified. [s. 53. (4) (a)]

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 behavioural triggers are identified for residents with responsive behaviours and that strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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. There is no documented evidence to support that the response provided to a complainant indicated what the licensee did to resolve the complaint. The Senior Administrator acknowledged that the response to the complainant did not clearly indicate what was done to resolve the concerns. [s. 101. (1) 3.]

2. A review of the complaint log revealed that there was no follow-up and documentation related to the final resolution of an identified complaint. The Senior Administrator acknowledged that there was no final resolution to the identified complaint. [s. 101. (2)]



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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 complaint procedures are revised to include that the licensee's response indicates what has been done to resolve the complaint and that there is a documented record of the final resolution, if any, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. A review of the Treatment Administration Record, for an identified resident, revealed that the resident did not consistently receive the treatment prescribed for a condition. There were 7 missed doses, in the one month and 10 doses were noted to be missed, in a 12 day period, in another month.

The Assistant Director of Care confirmed that the doses were missed and indicated the home's expectation is that all medications and treatments are to be given as prescribed. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.



WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. An identified resident's response to psychotropic medications were not monitored to ensure that the resident was not somnolent and at risk of falling. The resident fell several times and post-falls assessments were documented for each fall. However, the medication regime was not reassessed.

The Director of Care and Assistant Director of Care acknowledged that there should be an assessment of medications as part of every post-falls assessment and that residents receiving psychotropic medications need to be monitored. [s. 134. (a)]

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 is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response to the medication, to be implemented voluntarily.



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Issued on this 12th day of March, 2013

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

A handwritten signature in cursive script that reads "Ruth Hildebrand".