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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 22, 2013	2013_182128_0030	L-000750-13	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): October 21, 2013

During the course of the inspection, the inspector(s) spoke with the Regional Director, Registered Dietitian, Assistant Director of Care, 1 Registered Nurse, 1 Registered Practical Nurse, 3 Personal Support Workers, 1 Housekeeping Aide, 1 Maintenance Worker, 1 Dietary Aide, 11 Residents, and 2 Family Members.

During the course of the inspection, the inspector(s) observed care provided to identified residents, observed snack service and lunch meal, and reviewed the clinical record of an identified resident.

The following Inspection Protocols were used during this inspection:

Dining Observation
Nutrition and Hydration
Personal Support Services
Snack Observation

Findings of Non-Compliance were found during this inspection.

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for each resident is provided to the resident as specified in the plan.

A clinical record review revealed that an identified resident was to have falls prevention interventions in place, related to being at high risk for falls.
The identified resident was observed, on October 22, 2013, without the interventions in place as per the plan of care. Additionally, the call bell was not within reach.
A registered nursing staff member confirmed that care was not provided as per the resident's plan of care and indicated that the call bell and falls prevention interventions should have been in place, for safety, related to risk of falling. [s. 6. (7)]

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 care set out in the plan of care for each resident is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered at each meal.

At the lunch meal, October 21, 2013, it was noted that 7/36 (19.4%) residents were provided with milk. Residents were offered a choice of beverage but were not offered 250 millilitres of milk. Additionally, all residents were not offered water as per the planned menu.
Three Personal Support Workers and a Dietary Aide stated they were not aware that the planned menu indicated residents were to be offered 250 millilitres of milk.
The Registered Dietitian confirmed that the expectation is that the planned menu is followed and both water and milk are offered to all residents. [s. 71. (4)]

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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

Issued on this 22nd day of October, 2013

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

RUTH HILDEBRAND