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 sous la Loi de 2007 sur 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2016	2016_428628_0011	002209-16	Complaint

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET P.O. BOX 4000 COCHRANE ON P0L 1C0

Long-Term Care Home/Foyer de soins de longue durée

VILLA MINTO
241 EIGHTH STREET P.O. BOX 280 COCHRANE ON P0L 1C0

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

MARIE LAFRAMBOISE (628)

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): May 16, 17, 18, 19 and 20, 2016

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and annual program evaluation records.

This Complaint inspection was related to an intake regarding the immediate reporting of alleged, suspected or witnessed incidents of abuse; policy to promote zero abuse or neglect tolerance; immediate investigation, and the duty to protect residents and another complaint regarding fall prevention and the plan of care.

A Follow-up inspection #2016_428628_0010 and a Critical Incident System (CIS) inspection #2016_428628_0007 were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Resident Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aides, Rehabilitation Coordinator, Activity Coordinator, Manager of Administration and residents and their family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 care set out in the plan of care was provided to the resident as specified in the plan.

On May 18, 2016, Inspector #628 was told by the Substitute Decision Maker (SDM) that resident #006 was in a wheelchair and specific piece of equipment was not used. The SDM stated the resident had fallen previously and that the specific piece of equipment has not been used on other occasions.

On May 18, 2016, Inspector #628 reviewed the care plan for resident #006 that was provided to the Inspector by the ADOC which indicated to prevent serious injury the resident required use a specific piece of equipment when in their wheelchair.

During the inspection, resident #006 was observed in the dining room with the specific piece of equipment not in use.

Inspector #628 interviewed RPN #109 who stated that the resident #006's specific piece of equipment was not in use and should have been.

On May 19, 2016, Inspector #628 reviewed the health care records for residents #010, #011 and #012, who all were required to have a specific pieces of equipment as per their care plans. Resident #012 was observed sitting in their wheelchair and the specific piece of equipment was not in use.

On May 19, 2016, RN #100 was interviewed who confirmed that the specific piece of equipment for resident #012 was not used and the specific piece of equipment was not available for use for resident #012 and should have been. [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 the care set out in the plan of care regarding specific equipment is provided to residents as specified in the plan, specifically in regards to the use of specific equipment for residents #006 and #012, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was in place, and that the immediate investigation of any suspected abuse of a resident was complied with.

A complaint by a former staff member was submitted to the Director which alleged that PSW #105 abused residents #002, #003 and #004. The complainant reported that they faxed the home's management a letter regarding these issues on a certain date in January 2015.

The Inspector reviewed the home’s policy titled "Zero Tolerance of Abuse and Neglect - #LTC-630", last revised in December 2015. The policy required that any person receiving a report of witnessed or suspected abuse must take notes, that the DOC must investigate any alleged, suspected or witnessed abuse and report the findings immediately to the Director within 10 days including responses taken and complete the home’s incident report form. The policy required that the notes taken must be documented or written in a brief factual note (e.g. not allegations or opinion). The policy required that the DOC or Charge Nurse coordinate with others to fully investigate the incident, and complete the documentation of all known details of the reported incident. The CEO or DOC was required by the policy to determine the appropriate management action(s) to be taken as a result of the findings of the investigation (education, discipline, policy revision, mandatory reporting to relevant professional college). The CEO or DOC were required by the policy to maintain the official copy of the confidential file.

The DOC provided the Inspector a copy of the home's investigation notes. These were reviewed by the Inspector. No incident report form or investigation notes specific to the complainant's report of abuse were included, as required by the home's policy.

During an interview with the Inspector, the DOC confirmed that the home did receive an email by the complainant on a certain date in January 2015. The DOC confirmed that all investigation documentation was given to the Inspector. [s. 20. (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 that the written policy to promote zero tolerance of abuse and neglect of residents is in place, and that the immediate investigation of any suspected abuse of a resident is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 the person, who had reasonable grounds to suspect that the abuse of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector reviewed a complaint, which was reported to the Director in February 2015, regarding a former employee of the home who alleged that PSW #105 abused residents #002, #003 and #004 in December 2014 and January 2015.

A review of the complaint report alleged that the complainant observed PSW #105 physically and verbally abused residents. The report included that the complainant reported this alleged abuse to ADOC #104. The complainant also stated that a letter was sent to the home's management by fax on a specific day in January 2015, and an email in January 2015.

The Inspector interviewed the DOC who denied having received a faxed letter by the complainant. The DOC provided an email to the Inspector. The email was addressed to the DOC, the ADOC and an RN on a specific day in January 2015 which alleged physical and verbal abuse of residents by PSW #105.

During an interview with the Inspector, on May 18, 2016, PSW #105 stated that they recalled an incident when they were reprimanded by the Supervisor regarding resident #004. PSW #105 denied any of the other verbal or physical abuse alleged by the complainant.

During an interview with the Inspector, the DOC confirmed that they had received an email on a certain day in January 2015, alleging abuse of residents by a staff member and that this was not reported to the Director immediately on that day in January 2015 and should have been as required. [s. 24. (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 the licensee, who has reasonable grounds to suspect that the abuse of a resident by anyone had occurred, immediately report 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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the DOC worked regularly in that position, on site for at least 16 hours per week, as required by legislation related to the number of licensed beds in the home.

Villa Minto had 33 licensed beds and was required to have the DOC onsite for at least 16 hours per week.

On May 16, 2016, Inspector #628 reviewed a letter of complaint from a family member on a certain day in 2015, where the complainant stated that they were unable to find the DOC or ADOC to address their concerns.

On May 18, 2016, the family member was interviewed. The family member stated that they had difficulty accessing the DOC.

On May 17, 2016, Inspector #628 reviewed the DOC schedule from January to present and noted that there were outstanding dates that the DOC was not on site during the week of April 3-9, 2016 for eight hours. For the week of April 17-23, 2016 there were five hours where the DOC was not on site. During the week of April 24-30, 2016 there were eight hours that the DOC was not on site at the home.

On May 20, 2016, Inspector #628 interviewed the DOC who confirmed for the week of April 3-9, 2016 there were only eight hours where the DOC was on site. For the week of April 17-23, 2016 there were only 11 hours where the DOC was on site. During the week of April 24-30, 2016 there were only eight hours where the DOC was on site. The DOC confirmed that the home required the DOC to regularly work 16 hours per week, in that position on site at the home, and if the DOC did not work regularly in the home for the required time, the DOC should have. [s. 213. (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 the DOC works regularly in that position, on site for at least 16 hours per week, as required by legislation related to the number of licensed beds in the home, to be implemented voluntarily.

Issued on this 22nd day of July, 2016

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

Original report signed by the inspector.