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 11, 2017	2017_509617_0013	028985-16, 029176-16	Follow up

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

SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 27-29, 2017

This Follow Up Inspection is related to Compliance Orders (COs) issued during Inspection #2016_507628_001:
- CO #001 regarding resident bed rail use
- CO #002 regarding duty to protect

This inspection was conducted concurrently with Critical Incident (CI) Inspection #2017_671684_00001.

During the course of the inspection, the inspector(s) spoke with Executive Lead, acting Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Manager, family members and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_507628_0016	617
LTCHA, 2007 S.O. 2007, c.8 s. 19.	WN	2016_507628_0016	617
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_507628_0016	617

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provide direct care to the resident regarding their bed rails.

On June 27 and 28, 2017, Inspector #617 observed two bed rails in the guard position above the mattress of resident #002's bed. On both of those occasions resident #002 was lying in their bed.

A review of resident #002's care plan current to the time of inspection, indicated that when resident #002 was in bed, their bed was to be in a certain position and "NO bed rails on the bed". The care plan was signed as revised by RPN (RAI-c) #108.

Inspector #617 interviewed PSWs #103, #105, and #104 who reviewed resident 002's care plan together with the Inspector. PSWs #103, #105, and #104 all confirmed to the Inspector respectively that resident #002's care plan indicated that no bed rails were to be used on their bed. All three PSWs confirmed to the Inspector respectively that they would leave the bed rails up above the mattress of resident #002's bed when the resident was lying in bed. PSWs #103, #105, and #104 explained that when resident #002's bed was at a certain position, they were not able to position the bed rails below the mattress because there was no room between the floor and the bed frame. PSWs #103, #105 and #104 agreed that the care plan statement did not give clear direction to the staff for the resident's use of bed rails. PSWs #103, #105 and #104 reported that the care plan should indicate the position of the bed rails on resident #002's bed and that resident #002 was not using them.

In an interview with the acting DOC, they reported that the intention of the home was for resident #002 not to use bed rails on their bed, however the rails would not tuck below the mattress when in a certain position, and needed to be removed or their care plan to be revised to give clear direction. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in resident #007's plan of care was provided to the resident as specified in the plan related to bed rail use.

On June 27 and 28, 2017, Inspector #617 observed two bed rails up above the mattress of resident #007's bed. On both of those occasions resident #007 was not lying in bed.

A review of resident #007's bed rail risk assessment, indicated that neither the resident nor their Substitute Decision Maker (SDM) had requested the use of bed rails. A review of resident #007's care plan current to the time of inspection, indicated that the resident will remain free of injury, falls or accidents and to ensure bed rails were not on the bed as requested. The care plan was signed as revised by RPN (RAI-c) #108.

Inspector #617 interviewed PSWs #103, #105 and #104 who all reviewed resident 007's care plan together with the Inspector. PSWs #103, #105 and #104 all confirmed to the Inspector that resident #007's care plan indicated that no bed rails were to be used on their bed. All three PSWs confirmed to the Inspector that they would leave two bed rails up above the mattress on resident #007's bed all the time. PSW #105 then explained that resident #007's bed rails were not used as a restrictive or assistive device, and that all beds in the home had bed rails up above the mattress. PSW #105 reported that there were no beds in the home that didn't have bed rails attached to the beds. PSW #105 reported that the care plan should indicate the position of the bed rails on resident #007's bed and that resident #007 was not using them.

In an interview with the acting DOC, they reported that the intention of the home was for resident #007 not to use bed rails on their bed and they needed to be removed or their care plan to be revised to ensure correct provision of care. [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 written plan of care for resident #002 sets out, clear directions to staff and others who provide direct care to the resident regarding their bed rails, and to ensure that the care set out in resident #007's plan of care is provided to the resident as specified in the plan related to bed rail use, to be implemented voluntarily.

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.