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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2017	2017_671684_0001	005871-17, 011085-17	Critical Incident System

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

SHELLEY MURPHY (684), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 26-29, 2017.

This Critical Incident Inspection was conducted as a result of two critical incident reports, the home submitted, related to staff to resident abuse.

A Follow Up inspection #2017_509617_0013, was conducted concurrently with this Critical Incident inspection.

The inspector also conducted a tour of the resident care areas, reviewed residents health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personal records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s)# 617 and #684 spoke with the Executive Lead, Administrator, Acting Director of Care (Acting DOC), Maintenance Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aid, and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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 O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physician conducted a physical examination of each resident upon admission and an annual physical examination thereafter, and produced a written report of the findings of the examination.

A Critical Incident Report was submitted to the Director, for verbal abuse of resident #001 by RPN #115. Within the critical incident report DOC #113 indicated there was difficulty having the medical staff attend the home to regularly visit with the residents.

Inspector #684 reviewed the health records of resident's #001, #004, #005, specific to annual physicals that had been completed during a specific time period. Inspector #684 was unable to identify any completed resident physical assessments for resident #001, resident #004 and resident #005 during the specific time period.

In an interview with Inspector #684, Registered Practical Nurse (RPN) #105 said that annual physical exam records were to be documented in the resident charts.

Inspector #684 reviewed an email between Administrator #102 and Director of Care #113 in regards to a meeting that was held in March, 2017 with physicians and the Administrator in attendance. The email from the Administrator expressed concerns regarding coverage, availability and communication of the physicians for the residents.

Inspector #684 reviewed minutes from a Family Council meeting which identified that the Family council wished to advocate on behalf of the residents, having regular access to a physician. The meeting minutes further referenced complaints in regards to physicians that were reported to the Ministry of Long Term Care, and the outcome for a Resident Quality Inspection with Order(s) resulted in Villa Minto being cited for failing to enter into an agreement with attending physician and for not providing regular physical examinations.

Inspector #684 reviewed the Attending Physician Services Agreement signed by a physician which indicated that a comprehensive annual examination of the resident, at least once every twelve months, occurs.

Inspector #684 interviewed Acting Director of Care (Acting DOC) #101, who said that the physicians have not been compliant with following the Long-Term Care standards. [s. 82. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 a person who had 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. 2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

A Critical Incident Report that was submitted to the Director for a staff to resident verbal abuse incident which occurred. Resident #001 said a staff member told them "to stop crying, shut up and go to sleep".

Inspector #684 reviewed a letter which was written by DOC # 113 to resident #001. The letter indicated resident #001 brought their concern regarding the care they received on a specific day forward to the DOC.

Inspector #684 interviewed Acting DOC #101 who confirmed that the critical incident was reported late.

Inspector #684 reviewed the policy titled Duty to Report last revised December, 2015 which outlined that "Information to be reported immediately to the Ministry -Abuse of a resident by anyone or neglect." [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 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: 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #002.

Inspector #617 reviewed Critical Incident (CI) report that was submitted to the Director regarding improper/incompetent treatment of resident #002 that resulted in harm or risk to the resident. The CI report indicated that resident #002 was transferred in a specific manner by PSWs #111 and #110 and described the events that resulted in resident #002 being injured as a result of an unsafe transfer.

Inspector #617 reviewed resident #002's Resident Assessment Instument (RAI) assessment which indicated that the resident required total dependence of two staff for transferring in a specified manner. Resident #002's care plan indicated that they required to be transferred in a specified manner with two staff assisting the transfer.

A review of PSW's #111 and #110 training records indicated that they were trained in transferring residents in a specified manner.

A review of the home's procedure titled, "Transferring Residents-LTC-212", indicated the process of transferring the resident in the specified manner.

During an interview with PSW #110 they reported to Inspector #617 the events that lead to the resident being injured. PSW# 110 said to the Inspector that they had not followed the home's policy for transferring. [s. 36.]

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 staff are using safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 4th day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHELLEY MURPHY (684), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_671684_0001
Log No. / No de registre :	005871-17, 011085-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 2, 2017
Licensee / Titulaire de permis :	THE LADY MINTO HOSPITAL AT COCHRANE 241 EIGHTH STREET, P.O. BOX4000, COCHRANE, ON, P0L-1C0
LTC Home / Foyer de SLD :	VILLA MINTO 241 EIGHTH STREET, P.O. BOX280, COCHRANE, ON, P0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Chatelain

To THE LADY MINTO HOSPITAL AT COCHRANE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;
(b) attends regularly at the home to provide services, including assessments; and

(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a physician or a registered nurse in the extended class conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination.

The plan shall include, but not limited to identifying:

a) when and how all outstanding physicals will be completed, and;

b) how to sustain support of ensuring a physical examination of each resident is conducted and a written report produced of the findings of the examination, and;

c) who will monitor and track progress and ongoing compliance in this area

Please submit the written plan to Shelley Murphy, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, via fax (705)564-3133 or email SudburySAO.moh@ontario.ca by August 16, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that a physician conducted a physical

examination of each resident upon admission and an annual physical examination thereafter, and produced a written report of the findings of the examination.

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Inspector #684 reviewed the health records of resident's #001, #004, #005, specific to annual physicals that had been completed during a specific time period. Inspector #684 was unable to identify any completed resident physical assessments for resident #001, resident #004 and resident #005 during the specific time period.

In an interview with Inspector #684, Registered Practical Nurse (RPN) #105 said that annual physical exam records were to be documented in the resident charts.

Inspector #684 reviewed an email between Administrator #102 and Director of Care #113 in regards to a meeting that was held in March, 2017 with physicians and the Administrator in attendance. The email from the Administrator expressed concerns regarding the lack of coverage, availability and communication of the physicians for the residents.

Inspector #-684 reviewed minutes from a Family Council meeting which identified that the Family council wished to advocate on behalf of the residents, having regular access to a physician. The meeting minutes further referenced complaints in regards to physicians that were reported to the Ministry of Long Term Care, and the outcome for a Resident Quality Inspection with Order(s) resulted in Villa Minto being cited for failing to enter into an agreement with attending physician and for not providing regular physical examinations.

Inspector #684 reviewed the Attending Physician Services Agreement and signed by a physician which indicated that a comprehensive annual examination of the resident at least once every twelve months, occurs.

Inspector #684 interviewed Acting Director of Care (Acting DOC) #101, who said that the physicians have not been compliant with following the Long-Term Care

standards.

The decision to issue this compliance order was based on the severity which indicates potential for actual harm, the scope was a pattern affecting resident # 001, 004 and 005, and there is a previous compliance history issued in this area of the legislation; on November 2, 2015, Resident Quality Inspection #2015_401616_0019 under r.82 a Voluntary Plan of Correction and Written Notification were issued. (684)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shelley Murphy

Service Area Office /
Bureau régional de services : Sudbury Service Area Office