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
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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 |
|---|---|---|---|
| Apr 26, 2018 | 2018_679638_0008 | 005285-18 | Resident Quality Inspection |

### 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

RYAN GOODMURPHY (638), CHAD CAMPS (609)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): April 17 - 20, 2018.**

**The following intakes were inspected during this Resident Quality Inspection:**
**-One log was related to compliance order (CO) #001 from inspection report #2017_668543_0006, s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to the duty to protect residents from abuse and neglect;**
**-One log was related to CO #002 from inspection report #2017_668543_0006, s. 82 (1) of the Ontario Regulation (O. Reg.) 79/10, specific to examinations being conducted by the attending physicians;**
**-One log was related to CO #003 from inspection report #2017_668543_0006, s. 82 (4) of the O. Reg. 79/10, specific to written agreements with the attending physicians;**
**-Two logs were complaints submitted to the Director which were related to wound care, notification of change, nutrition, plan of care, complaints and nail/foot care; and**
**-One log was a complaint submitted to the Director which was related to attending physician involvement and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DORC), Human Resources Administrative Assistant, Executive Assistant, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their family members.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, relevant training and resident health care records.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Residents' Council**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **1 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2017_668543_0006 | 638 |
| O.Reg 79/10 s. 82. (4) | CO #003 | 2017_668543_0006 | 609 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 failed to ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produced a written report of the findings of the examination.

During inspection #2017_668543_0006, CO #002 was issued to the home to address the licensee’s failure to comply with O. Reg. 79/10, section 82, subsection 1. The CO directed the home to develop, prepare, submit and implement a plan that would include, but was not limited to; identifying a schedule that will ensure that either a physician or a registered nurse in the extended class, attends regularly at the home to provide services, including assessments. The compliance due date for the order was January 31, 2018.

Additional findings of non-compliance were identified related to incomplete physician admission and annual physical examinations of residents.

A review of the April 18, 2018, physician communication sheets found that resident #012 and #019 required their admission physician’s examinations be completed. Inspector #609 reviewed the health care records of resident #010, #012 and #019. The Inspector found that two of the three or 66 per cent of the residents had not had their physician’s examination completed, as required.

A review of the home’s policy titled “Attending Physicians and RNs (EC)” last revised October 16, 2017, required the physician or RN Extended Class to conduct a physical examination upon admission and annually thereafter, as well as produce a written report of the findings.

During an interview with Inspector #609, the DORC verified that all admission and annual physician examinations were supposed to be completed. The DORC verified that resident #012 and #019 did not have their physician examinations completed and it was most likely missed when another physician became these residents' attending physician at the beginning of 2018. [s. 82. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

---

**WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident, the resident's substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director which indicated that resident #009 had a specific treatment ordered to manage a specific diagnoses. The complaint indicated that the treatment was discontinued on a specific date in December 2017, without the SDM being made aware. The complaint alleged that they were not made aware of this change and that they would not have consented to discontinuing the resident's treatment as it was important to treat their specific diagnoses.

Inspector #638 reviewed resident #009's health care records and identified that the resident had their specific treatment discontinued on a specific date in December 2017.

The Inspector was unable to identify any documentation to support that the SDM was made aware of these changes, when the order was discontinued.

In an interview with Inspector #638, RPN #105 indicated that a resident's SDM would be notified of a change in the resident's status, treatment or care, right away, or when the SDM came to the home. The RPN indicated that they would preferably contact the SDM, at the time of the change, to make them aware sooner.

In an interview with Inspector #638, the DORC indicated that when a resident's medication orders changed, staff may not necessarily notify the SDM immediately and changes would be discussed during the family care conference. The DORC then indicated that changes in treatment or care should probably be relayed sooner. The Inspector reviewed when resident #009's specific treatment was discontinued with the DORC, who indicated that they were having difficulties with physician coverage at that time and it may have been discontinued without effectively communicating the changes. [s. 6. (5)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director which alleged that resident #009 was not being provided with their nutritional supplements as ordered. The complaint indicated that the resident was supposed to be offered a supplement when they did not consume the majority of their meal.

Inspector #638 reviewed resident #009's health care records and identified that the resident had been ordered a specific supplement on a specific date in March 2018. The supplement was supposed to be offered whenever the resident consumed less than a specific amount of their meal.

The Inspector reviewed the resident's intake record over a one month period in March and April 2018. The record identified that resident #009 ate less than the specified amount of their meal 69 times out of the 96 meal services during the review period, the resident ate less than the specified amount of their meal 72 per cent of the time.

The Inspector reviewed the electronic medication administration record (eMAR) and progress notes to identify when the resident received their supplement. Out of the 69 meals that the resident was supposed to be offered their supplement, it was documented

that the resident received their specific supplement on seven occasions (10 per cent of the time).

In an interview with Inspector #638, PSW #101 indicated that when a resident had diminished intake, they would be offered a nutritional supplement. The PSW stated that when a resident was provided with a supplement, they would notify registered staff to document the intervention had been administered.

During an interview with Inspector #638, RPN #107 indicated that whenever a resident was provided a nutritional supplement, staff should write a progress note indicating the amount consumed and document that the supplement was administered on the eMAR.

In an interview with Inspector #638, the DORC indicated that whenever a resident had decreased intake, with a supplement ordered, the PSW would document the amount of supplement taken and registered staff would document in the eMAR that the supplement was offered. The Inspector reviewed resident #009's intake record and eMAR with the DORC, who then indicated that they would not be able to identify if the resident received their nutritional supplement on the aforementioned dates, due to a lack of documentation. [s. 6. (9) 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 provision of the care set out in the plan of care for resident #009 and all residents is documented, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the programs included a weight monitoring system to measure and record weight with respect to each resident, on admission and monthly thereafter.

During a record review, Inspector #638 and #609 identified that resident #001, #002, #005, #009, #013, #014, #015, #016 and #018's weights weren't documented for March 2018, resident #017's weight had not been recorded for April 2018, and resident #006's weight was not recorded for January and March 2018.

In an interview with Inspector #638, PSW #101 indicated that PSWs check and document weights monthly under the weights tab on Point Click Care (PCC). The PSW indicated that a prompt on PCC reminded staff that the resident's weight was due to be checked. The Inspector reviewed resident #009's weight record with PSW #101, who indicated that it was possible that staff didn't get to it, but it should have been identified if it was missed. The PSW was unable to identify if the resident was weighed for the aforementioned dates.

During an interview with Inspector #638, RPN #107 indicated that PSWs were to weigh residents monthly, but no one was assigned to review and ensure that these weights were completed. The RPN indicated that if a weight was not completed, it would be missed, unless someone happened to notice the discrepancy.

The home's policy titled "Weight & Height Change - LTC-N-416" dated December 15, 2015, indicated that all residents will be weighed on admission and monthly as per the nursing policy.

In an interview with Inspector #638, the DORC indicated that weights were checked monthly by PSWs and documented in PCC under the weights tab. The DORC indicated that if a weight was missed, there was no follow up to ensure that it was completed. The Inspector reviewed resident #009's weight records with the DORC, who indicated that the resident did not have a weight recorded in March 2018, and this could have been related to staffing concerns during that month but, the weights still should have been checked. [s. 68. (2) (e) (i)]

***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 weights, for all residents, are recorded on admission and monthly thereafter, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and the doors kept closed and locked when they were not being supervised by staff.

During the initial tour of the home on April 17, 2018, at 1325 hours, the Inspector noted that three doors to the tub room were unlocked and unattended. The Inspector also noted that the dirty utility room doors left propped open while left unattended. The Inspector identified a note posted on the dirty utility room which directed staff to ensure that the door was kept closed and locked.

In an interview with Inspector #638, PSW #102 indicated that both the dirty utility room doors and tub room doors were supposed to be kept locked and closed, when not in use by staff. The Inspector observed the PSW close and lock each door because there were no staff members supervising the area.

During an interview with Inspector #638, RPN #105 indicated that the tub room and dirty utility room doors were supposed to be kept locked and closed, when not in use by staff. The RPN indicated that the door could be left unlocked when bringing a resident to the tub room, but if there were no staff monitoring the area, the doors should have been kept closed and locked.

In an interview with Inspector #638, the DORC indicated that tub room doors were generally kept locked and that the dirty utility room doors should be locked at all times. The DORC indicated that they expected these doors to be kept locked when staff were not in attendance of the area and this had been an issue identified by the home in the past. The DORC indicated that leaving these doors unlocked and unattended posed a risk to the residents and should be kept locked for resident safety. [s. 9. (1) 2.]

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the Director which alleged that resident #009 developed an area of altered skin integrity to a specific area. The complaint alleged that early in 2017, the resident developed an area of altered skin integrity and staff were not aware of the area of impaired skin integrity.

Inspector reviewed resident #009's health care records and identified that on a specific date in January 2017, the "Cochrane Foot Care Wellness Centre" RPN completed a visit and documented that the resident had an area of altered skin integrity to a specific location. The Inspector identified a progress note written by the DORC a few days after the aforementioned document was created, which indicated that they had seen the area of altered skin integrity on the resident and care would be taken to monitor the area and relieve pressure.

The Inspector was unable to identify any completed skin and wound assessments for resident #009's area of altered skin integrity during the month of January 2017.

In an interview with Inspector #638, PSW #101 indicated that they monitored resident skin integrity daily, during care giving periods and completed skin assessments on bath days. The PSW stated that if an area of altered skin integrity was noted, registered staff would be notified.

During an interview with Inspector #638, RPN #107 indicated that any reddened area, pressure ulcer or skin tear would be considered an area of altered skin integrity, which required assessment. The Inspector reviewed resident #009's documentation regarding the area of altered skin integrity with the RPN, who indicated that there should have been an assessment documented to monitor the new area of altered skin integrity. The RPN was unable to identify any completed assessment related to this incident.

The home's policy titled "Skin and Wound Care Program - LTC-003" last reviewed February 16, 2017, indicated that upon discovery of a pressure ulcer, staff are to initiate a baseline assessment using a clinically appropriate assessment instrument in PCC for Long-Term Care residents.

In an interview with Inspector #638, the DORC indicated that whenever a resident developed a new area of altered skin integrity, registered staff should complete a skin and wound assessment located in the assessments tab of PCC. The Inspector reviewed resident #009's health care records related to the area of altered skin integrity in January 2017. The DORC stated that they were unable to locate any completed skin and wound assessment and indicated that the skin assessment should have been completed and the home recently implemented a new tracking tool to minimize the risk of this occurring in the future. [s. 50. (2) (b) (i)]

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident's SDM, if any, the prescriber of the drug, and the resident's attending physician.

Inspector #609 reviewed three of the home's most recent medication incident reports, as well as health care records for residents #010, #011, #003 who were involved in the incidents. Of the three medication incident reports, one (33 per cent) had no indication that the SDM, the prescriber of the medication or the attending physician were notified.

A further review of the medication incident identified, described how on the three previous days resident #010 was not given their daily dose of a specific medication, because RN #103 failed to properly check the medication cart and documented the medication as not available.

The home's policy titled "Medication Incident Reporting" dated 2017, required every medication incident involving a resident to be reported to the resident's SDM as well as the attending physician.

A review of resident #010's health care records failed to produce any documentation that the resident's SDM was notified of the medication incident.

A review of the physician communication sheet failed to produce any documentation that resident #010's attending physician was notified of the medication incident.

During an interview with Inspector #609, RN #103 indicated that they thought resident #010's medication was not available when they failed to properly check for the medication in the medication cart. The RN verified that they were aware of the home's policy to report any medication incident to the resident's SDM and attending physician and that they did not do so.

During an interview with Inspector #609, the DORC reviewed the medication incident with the Inspector. The DORC stated that all medication incidents were supposed to be reported to the resident's SDM with a corresponding health care record note and reported to the attending physician through the physician communication sheet. The DORC verified that this did not occur for resident #010's medication incident. [s. 135. (1)]

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records**

**Specifically failed to comply with the following:**

**s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

A complaint was submitted to the Director, which outlined allegations of neglect of resident #008.

Inspector #609 reviewed resident #008's electronic health care record and found that the resident passed away on a specific date in 2017.

On April 19, 2018, the Inspector requested the physical chart and health care records for resident #008, from the DORC. The Inspector was not provided with the requested information.

The home's policy titled "Records Retention and Destruction" last revised November 15, 2015, required a resident's care records be retained by the home for a minimum of 10 years after the death or discharge of a resident.

During an interview with the DORC, they indicated that they were unable to locate resident #008's physical chart. The DORC verified that the records were to be retained by the home for at least 10 years after discharge. [s. 233. (1)]

**Issued on this 26th day of April, 2018**

| |
|---|
| **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) :** | RYAN GOODMURPHY (638), CHAD CAMPS (609) |
| **Inspection No. / No de l'inspection :** | 2018_679638_0008 |
| **Log No. / No de registre :** | 005285-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Apr 26, 2018 |
| **Licensee / Titulaire de permis :** | The Lady Minto Hospital at Cochrane<br>241 Eighth Street, P.O. Box 4000, COCHRANE, ON, P0L-1C0 |
| **LTC Home / Foyer de SLD :** | Villa Minto<br>241 Eighth Street, P.O. Box 280, 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) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2017_668543_0006, CO #002;

**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 must be in compliance with s. 82 (1) of the Ontario Regulation 79/10. Specifically the licensee must;

1. develop an auditing process to ensure that residents receive a physical examination on admission and annually thereafter.

2. train the staff responsible for ensuring the physical examinations are completed by the physician, to ensure they are aware of their role and its requirements. A record of when the training occurred and who the training was provided to, is to be maintained.

**Grounds / Motifs :**

1. The licensee failed to ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produced a written report of the findings of the examination.

During inspection #2017_668543_0006, CO #002 was issued to the home to address the licensee's failure to comply with O. Reg. 79/10, section 82,

subsection 1. The CO directed the home to develop, prepare, submit and implement a plan that would include, but was not limited to; identifying a schedule that will ensure that either a physician or a registered nurse in the extended class, attends regularly at the home to provide services, including assessments. The compliance due date for the order was January 31, 2018.

Additional findings of non-compliance were identified related to incomplete physician admission and annual physical examinations of residents.

A review of the April 18, 2018, physician communication sheets found that resident #012 and #019 required their admission physician's examinations be completed. Inspector #609 reviewed the health care records of resident #010, #012 and #019. The Inspector found that two of the three or 66 per cent of the residents had not had their physician's examination completed, as required.

A review of the home's policy titled "Attending Physicians and RNs (EC)" last revised October 16, 2017, required the physician or RN Extended Class to conduct a physical examination upon admission and annually thereafter, as well as produce a written report of the findings.

During an interview with Inspector #609, the DORC verified that all admission and annual physician examinations were supposed to be completed. The DORC verified that resident #012 and #019 did not have their physician examinations completed and it was most likely missed when another physician became these residents' attending physician at the beginning of 2018.

The severity of this issue was determined to be a level two, as there was a risk of actual harm to residents of the home. The scope of the issues was a level two, as it was related to two of the residents reviewed. The home had a level four compliance history, as they had ongoing non-compliance with this section of the Ontario Regulation 79/10 which included;

-one voluntary plan of correction issued January 15, 2016 (#2015_401616_0019);
-compliance order #001 issued August 2, 2017, with a compliance due date of September 15, 2017 (#2017_671684_0001); and
-compliance order #002 re-issued December 15, 2017, with a compliance due date of January 31, 2018 (#2017_668543_0006). (609)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 29, 2018

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  26th  day of April, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Name of Inspector / Nom de l'inspecteur :** Ryan Goodmurphy

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