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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2018	2018_657681_0022	017397-18	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

STEPHANIE DONI (681)

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): September 26 - 27, 2018. Additional off-site inspection activities were completed on September 28, 2018, and October 2, 2018.

The following intake was inspected on during this Critical Incident System inspection:
- One intake related to the improper treatment of a resident that resulted in harm or risk to the resident.

A Follow up inspection #2018_657681_0023, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Personal Support Workers (PSWs), Recreation Therapy and Volunteer Coordinator, family members, and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

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

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)**

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. 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 that promoted zero tolerance

of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A critical incident (CI) report was submitted to the Director, related to an allegation of improper treatment of a resident that resulted in harm or risk to the resident. The CI report indicated that resident #001 was treated inappropriately by PSW #105.

Inspector #681 reviewed the home’s investigation notes, which included separate written statements from PSW #106 and PSW #108. The written statements indicated that both PSW #106 and PSW #108 observed PSW #105 treat resident #001 inappropriately and that this caused the resident to yell out in pain.

The Inspector also reviewed a disciplinary letter addressed to PSW #105, which indicated that through the home’s investigation, it was revealed that there was a direct correlation between the PSW's actions and resident #001’s loud vocalization of pain.

During an interview with PSW #106, they stated that PSW #105 treated resident #001 inappropriately and the resident responded by yelling out in pain.

During an interview with RN #102, they indicated that, following the incident, resident #001 experienced a change in their mobility status.

The Inspector reviewed the progress notes in resident #001’s health record, which included a note entered by RN #102. The progress note indicated that RN #102 attempted to get resident #001 to participate in a specified activity of daily living (ADL), but that the resident did very poorly and requested the use of a specified mobility aid.

The Inspector reviewed the home's Policy titled "Zero Tolerance of Abuse and Neglect" - LTC-105, last reviewed February 15, 2018, which indicated that the MICs Group of Health Services believe that all residents have a right to dignity, respect, and freedom from abuse and neglect.

During an interview with the DOC, they indicated that the home believed that the incident met the definition of abuse. The DOC stated that resident #001 experienced pain and a change in their mobility status following the incident. The DOC also stated that the incident could have been prevented which was why disciplinary action was issued to

PSW #105. [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 to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

Issued on this 4th day of October, 2018

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

Original report signed by the inspector.