Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2019	2019_655679_0025	014861-19	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

MICHELLE BERARDI (679)

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 23-24, 2019. Additional offsite inspection activities were conducted on October 1, 2019.

The following intake was inspected upon during this Critical Incident (CI) Inspection:

- One intake related to a missing resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), previous DOC, Clinical Behavioural Response Specialist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, as well as relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 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	Légende 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: safety risk.

A) A Critical Incident (CI) report was submitted to the Director for a missing resident. The CI report identified that resident #001 did not return to the home at the expected time.

In an interview with PSW #108, they identified that resident #001 had a specified safety risk. PSW #108 identified that this should be outlined in the resident’s care plan.

Inspector #679 reviewed resident #001’s electronic care plan and did not identify a focus related to this resident’s safety risk.

B) In an interview with PSW #108 they identified that resident’s #002 and #003 had a specified safety risk.

Inspector #679 reviewed resident #002 and #003’s electronic care plan and did not identify a focus related to this resident’s safety risk.

In an interview with RPN #105 they identified that a resident’s care plan would outline if a resident had a specified safety risk and any interventions in place to manage this risk. RPN #105 confirmed that resident #001 had a specified safety risk. Together, Inspector #679 and RPN #105 reviewed the electronic care plan. RPN #105 identified that there was no specific focus related to the specified safety risk.

In an interview with RN #109 they identified that resident’s #001, #002 and #003 had a specified safety risk.

In an interview with previous Director Of Care (DOC) #103 they confirmed that a resident’s specified safety risk should be identified in the plan of care. Together, Inspector #679 and DOC #102 reviewed the care plans for residents #001, #002 and #003. DOC #102 identified that these residents had a specified safety risk, and that there was no focus related to these resident’s specified safety risk. [s. 26. (3) 19.]

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 ensuring that the plan of care is based on at a minimum an interdisciplinary assessment of the following with respect to the resident: safety risk, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Upon entrance to the home, Inspector #679 was informed that DOC #103 was no longer the DOC of the home. DOC #102 informed the Inspector that they were the new DOC for the home, and that their position started one week prior to this inspection.

In an interview with the DOC #102 they identified that they had two years and nine months experience in a management role. [s. 213. (4) (b)]

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 ensuring that everyone hired as a Director of Nursing and Personal Care has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting, 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 any person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was 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.

A Memorandum titled "Clarification of Mandatory and Critical Incident Reporting Requirements" dated July 05, 2018, was sent to the Long-Term Care Home Licensees

and Administrators. This memorandum identified 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 risk of harm to the resident”.

A CI report was submitted to the Director for a missing resident. The CI report indicated that resident #001 did not return to the home at the expected time. The CI report further indicated that the home was notified of potential abuse.

Inspector #679 reviewed this resident’s electronic progress notes and identified progress notes outlining suspected abuse.

In an interview with Inspector #679, PSW #108 identified that if they witnessed or suspected abuse they were to report to the nurse right away. Inspector #679 asked PSW #108 if there had been any concerns with suspected abuse related to resident #001, to which PSW #108 identified that they thought there was related to this incident.

Inspector #679 reviewed the Ministry of Long-Term Care’s online reporting portal and did not locate a CI report related to this allegation of abuse.

Inspector #679 reviewed the home’s policy titled “Zero Tolerance of Abuse and Neglect (LTC-105)” which was last revised February 15, 2019. The policy identified that the DOC/delegate or the charge nurse will notify the Director by completing the mandatory CI report on-line or after hours by calling the Ministry after- hour pager.

In an interview with RPN #105, they identified that if they were made aware of an incident of alleged abuse, they were to contact the DOC right away to fill out a CI report.

In an interview with previous DOC #103 they identified that they were aware of suspected abuse. Inspector #679 questioned if a CI report was submitted to the Director for this allegation of abuse, to which the previous DOC identified that there was not a CI report submitted related to this allegation of abuse. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 240. Reports re key personnel
Every licensee of a long-term care home shall report to the Director the name and contact information of,
(a) the Medical Director;
(b) any registered nurses in the extended class working in the home;
(c) the Administrator;
(d) the Director of Nursing and Personal Care;
(e) the nutrition manager;
(f) every registered dietitian who is a member of the staff of the home; and
(g) the designated lead for each of the housekeeping, laundry and maintenance programs. O. Reg. 79/10, s. 240.

Findings/Faits saillants :

1. The licensee has failed to ensure that the name and contact information of the Director of Nursing and Personal Care was reported to the Director.

Inspector #679 reviewed the contact information for the home which listed previous DOC #103 as the current DOC for the home.

Upon entrance to the home, Inspector #679 was informed that DOC #103 was no longer the DOC of the home. DOC #102 informed the Inspector that they were the new DOC for the home, and that their position started one week prior to this inspection.

In an interview with previous DOC #103 they identified they did not notify the Director of the changes to the DOC. [s. 240. (d)]

Issued on this 4th day of October, 2019

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

Original report signed by the inspector.