Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 22, 2020	2020_668543_0012	003991-20, 005823-20, 007472-20	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

TIFFANY BOUCHER (543), HILARY ROCK (765)

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): July 14-16, 2020

The following intakes that were submitted to the Director were inspected during this inspection:

One intake, related to abuse; and

Two intakes, related to missing residents.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW) and Recreation Therapist.

The Inspector also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, personnel files and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report was submitted to the Director on a date in 2020. According to the CI report, the Director of Care (DOC) received two internal reports outlining that a PSW had displayed inappropriate behaviours towards a resident. The behaviours were described as abusive and neglectful.

Inspector #543 reviewed a document, which identified that during a specific night in 2020, PSW #103 was providing specific care for resident #001. Throughout the night PSW #103 was described as displaying specific inappropriate behaviours towards the resident. PSW #103 also had inactivated a specific safety device for resident #001 and was observed not providing the specific care as required.

Inspector #543 reviewed investigation documents related to the incident that was submitted to the Director.

One document dated 23 days after the incident occurred, indicated that PSW #103,was scheduled to provide specific care for resident #001. RPN #102 and PSW #100 were doing rounds and they noticed that PSW #103 was not providing the care as they normally would be. RPN #102 and PSW #100 proceeded to enter the room to check on PSW #103 and witnessed them acting inappropriately towards resident #001. When PSW #103 saw the other PSW and RPN, they immediately stopped the way they were acting towards the resident.

Another document, indicated that PSW #104 was charting and PSW #103 was sitting at the desk, and that PSW #103 had acted and spoken inappropriately regarding resident #001.

A third document indicated that RPN #102 identified that RPN #102 and PSW #100 went to see if PSW #103 required assistance. When they got to resident #001’s room they observed PSW #103 was in the midst of providing care to resident #001, but that PSW #103 had been acting inappropriately towards resident #001. When PSW #103 saw the RPN and the other PSW their demeanor changed. RPN #102 brought this concern to the DOC. This document also identified, that PSW #103 had not been providing the care required for the resident and had inactivated a specific safety device that resident #001 required.

The Inspector reviewed the home's "Zero Tolerance of Abuse and Neglect" policy (LTC-105). This policy identified that the MICs Group of Health Services was committed to a zero tolerance of abuse or neglect of its residents.

Inspector #543 reviewed a document written by the Director of Human Resources. This document indicated that a number of witnesses had corroborated treatment of a specific resident in terms of specific types of abuse. The document identified that there was sufficient evidence of resident neglect and potential abuse. [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 the home's "Zero Tolerance of Abuse and Neglect" is complied with, to be implemented voluntarily.

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 failed to ensure that the person who had reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident, occurred or may occur, by the licensee or staff that resulted in harm or risk of harm; immediately reported the suspicion and the information upon which it was based to the Director.

A critical incident (CI) report was submitted to the Director on a specific date in 2020. According to the CI report, the Director of Care (DOC) received two internal reports outlining that on a date in 2020, a PSW had displayed inappropriate behaviours towards a resident.

Inspector #543 reviewed three separate investigation documents related to the incident that was submitted to the Director, 24 days after the incident occurred. See WN #1 for details.

Inspector #543 reviewed the home's "Zero Tolerance of Abuse and Neglect" policy (LTC-105). This policy identified that the MICs Group of Health Services was committed to a zero tolerance of abuse or neglect of its residents. The policy identified that under section 24 of the LTCHA, a person who had reasonable grounds to suspect that the 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 occurred or may occur, shall immediately report the suspicion and the information upon which it was based to the Director.

Inspector #543 interviewed PSW #100 who indicated that the process was to report to their manager, and that management would take it from there to report to the ministry. They stated that any abuse needed to be immediately reported.

Inspector #543 interviewed the DOC who indicated that abuse needed to be reported immediately, and that the incident that occurred, was not reported immediately. [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 any person who has reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident, occurred or may occur, by the licensee or staff that results in harm or risk of harm; immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.