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
Nov 26, 2020	2020_752627_0018	018009-20, 021760-20	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

SYLVIE BYRNES (627)

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): November 17-19, 2020.

The following intakes were completed in this critical incident system (CIS) inspection:

- One intake related to alleged staff to resident abuse; and,
- One intake related to a medication error.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Acting Specialty Care Registered Nurse, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedure, programs, internal investigation documents and resident health care records.

The following Inspection Protocols were used during this inspection:
Medication
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the RPN administered drugs to a resident in accordance with the directions specified by the prescriber.

A resident was supposed to receive a medication at 2000 hours; however, the RPN administered the medication to the resident at 0800 hours.

The home's policy titled "The Medication Pass", last revised January 2018, indicated that the right resident received the right medication, the right dose, at the right time, by the right route for the right reason".

The DOC acknowledged that the medication was not given at the right time.

Sources: Medication administration record (MAR), Narcotic control sheet, investigation notes, physician's orders, home's policy titled "The Mediation Pass", last revised January, 2018, interviews with an RPN and the DOC. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that an RPN provided care to a resident as set out in the plan of care.

A resident’s plan of care indicated that the resident was to have an intervention in place to prevent further skin breakdown.

The home's policy titled, "Skin and Wound Care Program", last revised March 15, 2018, indicated that the purpose of skin care and wound management was to reduce and mitigate the overall incidence of pressure ulcers by relieving pressure from bony prominences using devices such as heel boots, and to develop, implement and update the plan of care.

The RPN did not follow the resident’s plan of care and apply the intervention, despite knowing of the resident's medical diagnosis.

The DOC stated that the RPN had not followed the resident's plan of care.

Sources: Critical incident report, emails from an RN to staff of huddle discussions, progress note from Specialty Care RN, dashboard entry in Point Click Care (PCC) for a resident , home's policy titled, "Skin and Wound Care Program", last revised March 15, 2018, interviews with a PSW, an RN and the DOC. [s. 6. (7)]

Issued on this 30th day of November, 2020

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

Original report signed by the inspector.