Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
Telephone: (800) 663-6965
sudburysao.moh@ontario.ca

Original Public Report

Report Issue Date: October 25, 2022	
Inspection Number: 2022-1302-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: The Lady Minto Hospital at Cochrane	
Long Term Care Home and City: Villa Minto, Cochrane	
Lead Inspector Amanda Belanger (736)	**Inspector Digital Signature** Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2022.10.25 09:21:30 -04'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 20-21, 2022.

The following intake(s) were inspected:

- Three logs related to allegations of resident to resident abuse, and
- One log related to complaint regarding essential caregivers.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Matters to the Director

NC#001 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: LTCHA, 2007 *s. 24 (1) 2*

The licensee has failed to ensure an allegation of resident to resident abuse involving two residents was immediately reported to the Director.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director, for an incident of resident to resident abuse that took place the day prior

The Director of Care (DOC) confirmed that the incident took place the day prior to the incident being reported, and should have been reported immediately.

Sources: CI report; the resident's progress notes; licensee policy titled Zero Tolerance of Abuse and Neglect; and, interview with DOC.

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WRITTEN NOTIFICATION: Visitor Policy

NC#002 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O.Reg. 246/22, s. 267 (1)

The licensee has failed to ensure that the written visitor policy for the home was implemented, related to ensuring that essential visitors still had access to the long term care home during an outbreak of a communicable disease.

Rationale and Summary
a) The licensee policy's, titled "Visits at Long Term Care Homes during COIVD-19", LTC-180, last revised March 2022, indicated that each resident could designate four essential caregivers, and that if the resident was in isolation, symptomatic, or in a declared outbreak area, the resident was permitted to

have one caregiver at a time.

A family member informed the Inspector that the home had prevented all essential caregivers from entering the home to provide assistance to residents. The family member further informed the Inspector that they had formally requested entry to the home to be able to provide ongoing essential care to their loved one, and that the request was denied**.**

Both the DOC and Infection Prevention and Control (IPAC) lead indicated that the home made the decision to stop all essential caregivers into the home on a specific date, and that the decision would be re-evaluated five days later; as well the DOC confirmed that prior to the home stopping all essential caregivers, only one essential caregiver was allowed into the home for the duration of the outbreak.

b) The DOC also indicated that over a six month period, the home had a total of 10 days where, due to lack of staffing, the home could not have any general visitors or essential caregivers into the home.

Sources: Inspector observations; licensee policy titled "Visits at Long Term Care Homes during COIVD-19", LTC-180, last revised March, 2022; email communications between the home and family members; interviews with family members, DOC, IPAC lead and other staff.

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