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

North District
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Original Public Report

Report Issue Date: July 25, 2023.	
Inspection Number: 2023-1302-0002	
Inspection Type: Proactive Compliance Inspection	
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 Belanger Digitally signed by Amanda Belanger Date: 2023.09.11 08:10:47 -04'00'
Additional Inspector(s) Steven Naccarato (744)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-22, 2023

The following intake was inspected:

- Intake: #00090083, a Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

During an initial tour of the home, there was no policy to promote zero tolerance of abuse and neglect of residents posted in the home.

In an interview with the Director of Care (DOC), they stated that the policy had not been posted but they would print and post the policy immediately.

The risk to residents for not having the policy to promote zero tolerance of abuse and neglect of residents in the home was low.

Sources: Inspector #744 observations; and, an interview with the DOC.

[744]

Date Remedy Implemented: June 22, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (r)

The licensee has failed to ensure that the explanation of Whistle-blower protection was posted in the home.

During an initial tour of the home, there was no explanation of Whistle-blower protection posted in the home.

In an interview with the DOC, they stated that the relevant document had not been posted in the home but was to be printed and posted immediately.

The was risk to residents for not having the explanation of Whistle-blower protection posted in the home was low.

Sources: Inspector #744 observations; and, an interview with the DOC.

[744]

Date Remedy Implemented: June 22, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the Visitor's Policy was posted in the home.

During an initial tour of the home, there was no Visitor's Policy posted in the home.

In an interview with the DOC, they stated that the Visitor's Policy had not been posted but was to be printed and posted immediately.

The was risk to residents for not having the visitor's policy posted in the home was low.

Sources: Inspector #744 observations; and, an interview with the DOC.

[744]

Date Remedy Implemented: June 22, 2023

WRITTEN NOTIFICATION: Nutrition and Hydration Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the nutrition and hydration program, and policies were evaluated and updated at least annually in accordance with evidence based practices, and if there were none, in

accordance with prevailing practices.

Summary and Rationale
The Inspector requested policies from the home's Nutrition and Hydration Program. The requested policies had not been reviewed or revised in the last calendar year.

The Registered Dietician (RD) indicated that they had been made aware in February, 2023, that the policy and program was outdated; and that they had updated it in March, 2023, however, the updates had not been put into practice at the time of the inspection.

The DOC indicated that they were aware that the Nutrition and Hydration program and policies needed to be reviewed and revised.

Sources: licensee policies; and interviews with the RD, and DOC.

[736]

WRITTEN NOTIFICATION: Resident and Family Satisfaction

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (d)

The licensee has failed to ensure that they were able to provide, during an inspection, the documentation to demonstrate that the resident and family satisfaction survey has been made available to Residents' Council, and the acts that the home had undertaken to improve the long-term care home based on the results of the survey.

Summary and Rationale
The home was unable to provide documentation to demonstrate that the survey had been shared with Residents' Council, or that the home had undertaken any actions to improve the long-term care home based on the results of the survey.

There was no risk to the residents, as a result of the home not being able to provide documentation related to the action plan.

Sources: Resident and Family Satisfaction Survey; Residents' Council meeting minutes; interviews with ADOC, DOC, and Administrator.

[736]

WRITTEN NOTIFICATION: Doors in the Home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that a door leading to the outside of the home was kept closed and locked.

Rationale and summary
During an initial tour of the home, an exit door leading to the outside of the home was observed to be ajar.

The maintenance manager of the home had repaired the door to prevent the door from remaining ajar; however, the door was observed to be ajar again during the inspection.

There was no known harm to residents at the time of the inspection for not having the door closed and locked.

Sources: Inspector #744 observations on June 19-22, 2023; and, interviews with the DOC, and other staff.

WRITTEN NOTIFICATION: Air Temperatures

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)

The licensee has failed to ensure that the temperature was measured and documented in two resident rooms, and a common area in the morning, between 12-5pm, and in the evening.

Summary and Rationale
The records provided did not always have the temperature recorded; there were dates and times when only one resident room, or no resident rooms were monitored for the temperature, and dates and times when resident common area temperatures were not monitored and documented.

The DOC confirmed that the temperatures were not being recorded in the areas, and at the times required.

Sources: Air Temperature Logs, policy "Cooling and Air Temperature Requirements for Long Term Care" , Number LTC 208, last revised June 2023; and interview with the DOC.

[736]

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that residents received, a minimum, two baths per week.

Summary and Rationale
The Inspector reviewed Point of Care (POC) documentation for bathing for specific residents, and noted that those residents were not documented to have been given, at minimum, two baths per week.

The DOC indicated that if a bath was not performed, or refused, the expectation would be that a progress note would be made in the resident's chart, and that the bath would be reoffered.

Sources: Specific residents' progress notes and POC documentation, as well as care plans; interview with the PSW and DOC.

[736]

WRITTEN NOTIFICATION: Menu Approval

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c) (iii)

The licensee has failed to ensure that the menu was reviewed for nutritional adequacy taking into consideration the Dietary Reference Intakes (DRIs) relevant to the resident population.

Summary and Rationale
The home provided the "Menu Approval Audit Tool" for the Summer Menu 2023, which indicated that a

nutrient analysis of the menu to ensure that it met the daily nutrient targets, was not completed.

There was minimal risk of harm to the residents.

Sources: Menu Approval Audit tool; license policy titled "Menu Planning", LTC-414, last revised July 2021; and, an interview with the RD.

[736]

WRITTEN NOTIFICATION: Meal Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.

The licensee has failed to ensure that residents were provided with sufficient time to eat at their own pace.

Summary and Rationale
The Inspector observed at breakfast that many residents were still eating their cereal when their main breakfast was placed in front of them. At lunch on the same date, the Inspector observed multiple residents being given their soup, main meal, and being offered dessert prior to finishing eating their soup and main meal.

The DOC confirmed that residents feeling rushed in the dining room was an ongoing concern that the home was attempting to addressing, and that having multiple courses placed in front of a resident at once, could lead to a resident feeling rushed to complete their meal.

There was low risk by residents not being provided sufficient time to eat their meals at their pace.

Sources: Inspector observations; Resident Council Meeting Minutes; and interview with the DOC, and RD.

[736]

WRITTEN NOTIFICATION: IPAC

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

a) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented related to monthly surveillance data trend analysis of symptoms indicating the presence of infection in residents.

Rationale and summary
According to the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, the licensee shall ensure that the symptom screening information gathered under subsection 102(9) of the Regulation is analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The home was unable to provide supporting evidence to indicate that monthly surveillance data trend analysis was completed. In an interview with the DOC they stated that they were not aware of any monthly surveillance of symptoms indicating the presence of infection in residents.

Sources: IPAC Standard for Long-Term Care Homes, dated April 2022; Home's policy titled "Surveillance Program" last date reviewed August 19, 2022; Interviews with the DOC and other staff.

b) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented related to hand hygiene.

Rationale and summary
According to the IPAC Standard for Long-Term Care Homes, dated April 2022, the home's IPAC program must include support for residents to perform hand hygiene (HH) prior to receiving meals and snacks, and after toileting.

During multiple observations of breakfast and lunch meal services, the inspectors observed that most residents were not supported with hand hygiene prior to the residents receiving their meals.

The DOC stated that staff are expected to assist residents with hand hygiene when they enter the dining room before meals.

There was low risk to the residents who did not receive assistance with hand hygiene.

Sources: Inspector observations of breakfast and lunch meal service on June 20-22, 2023; The homes policy titled "Hand Hygiene", last revised November 18, 2022; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022; Interviews with the DOC and other staff.

[744]

WRITTEN NOTIFICATION: Medication Policies

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to ensure that medication policy related to the destruction of surplus insulin was complied with.

Summary and Rationale
O. Reg 246/22 s. 11 (1) (b) requires that where the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy; the licensee is required to ensure that the policy is complied with.

The policy titled "Drug Destruction and Disposal", was part of the home's medication management policies, and directed the home to log all disposed insulin on the Drug Destruction and Disposal Log for Non-Narcotic/Non-Controlled medications and to complete the required documentation.

The ADOC confirmed that the home was not utilizing the the logs to document the destruction of insulin, as per the home's medication policy.

There was moderate risk by the home not implementing the policy to monitor the destruction of insulin.

Sources: Inspector observations; licensee policy titled "Drug Destruction and Disposal" 5-4; and, interview with the ADOC.

[736]

WRITTEN NOTIFICATION: Destruction of Non Controlled Medications

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b) (ii)

The licensee has failed to ensure that drugs being destroyed by a team acting together and composed of a registered nursing staff and one other staff member appointed by the DOC.

Summary and Rationale
The home was unable to provide documentation to show that two staff members, including one member of the registered nursing staff were present while medications were being destroyed.

The DOC indicated that two staff, including one member of the Registered Staff were to witness non controlled medications being placed into destruction together.

There was minimal risk of harm to the residents.

Sources: CareRx policy 5-4, Drug Destruction and Disposal; interview with the RPN, and the DOC.

[736]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)

The licensee has failed to ensure that the home had established a continuous quality improvement committee.

Summary and Rationale
The home was unable to provide any records to demonstrate that they had established a continuous quality improvement committee.

The ADOC, who self identified as the lead of the QI program for the home, indicated that the home had not yet established a continuous quality improvement committee.

There was minimal risk to the residents by the home not having implemented a quality improvement committee.

Sources: interview with the ADOC, DOC and Administrator.

[736]