



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 sous la Loi de 2007 sur les foyers de soins de longue durée

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 22, 2013	2013_140158_0021	S-00166-13, S-000171-13,	Complaint

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 12, 13, 14, 15, 2013

Log # S-00166-13, S-000171-13

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed various home policies and reviewed resident health care records.

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

Findings of Non-Compliance were found during this inspection.

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**

Legendé

**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. 114. Medication management system

Specifically failed to comply with the following:

- s. 114. (3) The written policies and protocols must be,**
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).
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Findings/Faits saillants :



1. The licensee did not ensure that written policies for medication administration were implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Resident # 02 receives a medication to manage pain and decrease agitation related to pain. The Inspector noted that according to the resident's Medication Administration Record (MAR), resident # 02 received a pain medication on ten different days. These days contradict with what was signed as given on the narcotic record. The ADOC confirmed that the pain medication is signed on the MAR and on the narcotic record. The home's medication administration policy was not implemented as six administrations of the pain medication were not signed as given on the MAR. [s. 114. (3) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



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1. The licensee did not ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident # 02 received a pain medication 17 times in one month and 3 times in another month. The effectiveness of the drug was evaluated in resident # 02 progress notes two times (even though there is no indication that the drug was administered on one of the days) and on the prn medication sheet three times. The effectiveness of the pain medication however was not evaluated 13 out of 20 times the drug was administered to resident # 02. [s. 134. (a)]

Issued on this 22nd day of August, 2013

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

A handwritten signature in cursive script, appearing to read "Schubert", is written in the signature box.