Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, 2016	2015_401616_0019	029572-15	Resident Quality Inspection

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

JENNIFER KOSS (616), CHAD CAMPS (609), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 2-6, November 9-12, 2015

Additional intakes completed during this inspection included a Follow Up to Inspection #2015_380593_0020, and a Complaint related to staffing, and the provision of a resident's personal care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Chief Nursing Officer (CNO), Infection Control Lead (ICL), Pharmacist, Registered Dietitian, Director of Support Services, Maintenance staff, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and Substitute Decision Makers (SDM)/family members.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

18 WN(s)
9 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 110. (2)	CO #004	2015_380593_0001	594
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_380593_0001	594
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2015_380593_0001	616

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of the long-term care home to have, institute or otherwise put in place a policy, the licensee did not ensure that the policy was in compliance with and was implemented in accordance with applicable requirements under the Act, and was complied with.

During a meeting with the DOC, Inspector #616 requested the home's most current policy related to Zero Tolerance of Abuse and Neglect. They provided a binder of current policies titled “Annual Education Villa Minto” for the Inspector's reference. On review of policy #LTC-630 Zero Tolerance of Abuse and Neglect, the last revision date was noted to be December 5th, 2012. The Inspector reviewed the policy with the DOC who confirmed this dated copy was the most up to date.

Within the current policy, section F – Dealing with Persons who have abused/neglected or alleged to have abused/neglected residents, remained unchanged after a Compliance Order #003 was issued in inspection #2015_380593_0020 served April 27, 2015. The licensee was ordered to review and ensure by April 30, 2015, that the policy directed that persons who have abused/neglected or alleged to have abused/neglected are immediately suspended or placed in a position that does not allow access to residents, pending the investigation.

The current policy, unchanged, allowed for staff members who have abused or alleged to have abused a resident, to continue to work in the home providing direct care during the investigation and pending the determination of the allegations to be factual.

This policy does not meet the requirements of section 20 under the LTCHA, 2007. [s. 8. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and if there were none, in accordance with prevailing practices, to minimize risk to the resident.

On November 4, 2015, Inspector #609 observed resident #007's bed system with bed rails engaged.

A review of resident #007's plan of care by Inspector #594 indicated bed rails to be up when in bed for comfort.

In an interview with Inspector #594, RN #104 indicated that nursing and therapy staff are to conduct the resident assessment for bed rails and document in a therapy assessment in the resident's health care record. The Inspector reviewed resident #007's health care record including the therapy assessment, which failed to document that the resident was assessed and the bed system evaluated. The Inspector reviewed the progress notes on the day of admission which documented that a direct care staff reported to the registered staff that the resident's bed rails were put up in afternoon so they would apply them in the evening to ensure safety.

The Inspector reviewed the home's Side Rails policy #L.05.05 (Revised Date February 2006) which indicated the need for side (bed) rails to be assessed prior to all applications, the need for side rails should be documented and the number of rails on the Resident Care Plan/Kardex under Safety. The policy further stated that the "Quarterly summary and Notes should be used to document the use of the rails and the continued assessment of the resident's tolerance to the aids".

Inspector #594 reviewed the Resident Assessment Instrument Minimum Data Set (RAI MDS) quarterly summaries for the resident which documented no use of bed rails since admission despite the direction to use bed rails in the plan of care.

In an interview with the Inspector, the DOC indicated that the home does not assess the residents or evaluate the bed system where bed rails are used. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living was included in a resident's plan of care only if alternatives to the use of a PASD had been considered.

In November 2015, Inspector #609 observed resident #007 with a Personal Assistance Services Device (PASD) used on 5 different occasions.

Review of the resident's care plan documented the use of the PASD. The Inspector was unable to locate documentation of alternatives to the use of the PASD. As the Inspector observed, the PASD had a restraining effect, which limited or inhibited the resident's movement.

Review of the home's Personal Assistance Services Devices (PASDs) Use policy #R-42 (last date reviewed February 20, 2013) documented that the assessment was to be carried out collaboratively by an interdisciplinary team and the assessment team will consider and try alternatives to the use of the PASD.

In an interview with the Inspector, the DOC indicated that no alternatives to the use of the PASD had been considered for resident #007. [s. 33. (4) 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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident’s substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment was required.

The most recent full Resident Assessment Instrument Minimum Data Set (RAI MDS) for residents #001, #002, #003, and #006 indicated they each had oral/dental problems. Inspectors #594 and #616 reviewed the health records for each resident which did not document that an annual dental assessment had been offered.

In an interview with Inspector #594, a multidisciplinary team member and RN #104 indicated that an annual dental assessment generally is offered during the annual care conference but is not documented. During the same interview they indicated that there was no dental service available at the home to complete the dental assessment.

Inspector #594 interviewed a family member of resident #002, who had an annual care conference in 2015, and they reported that there was no annual dental assessment offered.

During an interview with Inspector #594, the DOC indicated that no annual dental assessment or other preventive dental services were offered to residents. [s. 34. (1) (c)]

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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations of 10 resident rooms made by Inspector #609 on November 3, 2015, revealed four rooms, or 40 per cent had unlabelled personal items which included denture cups, brushes and combs.

RN #100 stated to Inspector #609 that the expectation of the home is that all personal items, including personal aids such as dentures, glasses and hearing aids were to be labelled within 48 hours of admission and of acquiring new items. They confirmed the unlabelled personal items were not in compliance with the Regulation and the items should have been labelled. [s. 37. (1) (a)]

2. On November 3, 2015, resident #002 was observed with facial hair. During an interview with Inspector #594, PSW #103 indicated that there was only one electric razor in the residents' shared bathroom and they were not sure if it had been used by the co-resident.

On November 10, 2015, the inspector observed two unlabelled electric razors in the resident's bathroom.

According to the Inventory of Non-Clothing Items policy #C:20 (Revised Date May 2006) the resident/representative are encouraged to label the item, such as electric shaver, and hair grooming items. If this is not possible, staff will assist in the labelling.

During an interview with Inspector #594, RN #100 indicated that all resident personal items were to be labelled. [s. 37. (1) (a)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s weight monitoring system recorded with respect to each resident, their weight on admission and monthly thereafter.

A review of health records by Inspectors #609, #594, and #616 revealed 27 of 30 residents or 90 per cent did not have monthly weights completed for 2015, with some residents having as many as five months of weight not measured.

A member of the multidisciplinary team confirmed to Inspector #609, the home's expectation was that weights were to be measured for each resident upon admission and monthly thereafter. They stated in the case of the 27 cited residents, this did not occur and should have.

In a telephone interview with the DOC, they confirmed that weights were to be completed monthly. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that the home’s weight monitoring system recorded with respect to each resident, their height on admission and annually thereafter.

A review of the health records revealed 23 of 28 residents, or 71 per cent did not have annual heights measured for the 2015 year.

In an interview with a member of the multidiscipinary team and Inspector #609, they confirmed that it was an expectation of the home that heights were to be measured for each resident upon admission and annually thereafter, that in the case of the 23 cited residents this did not occur and should have.

The DOC confirmed in a telephone interview with Inspector #609 the expectation that heights were to be completed annually. [s. 68. (2) (e) (ii)]

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 Nutrition Care and Hydration programs include weight on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that either a physician or registered nurse in the extended class, conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produced a written report of the findings of the examination.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on May 6, 2015, citing that resident health concerns were potentially not being followed up.

The DOC stated to Inspector #594 there were four active attending physicians for the home.

An audit by the Inspector of completed admission physical examinations was conducted for one resident per Attending Physician of the home. The audit revealed two of four, or 50 per cent of the residents reviewed did not have a physical examination completed within one year of admission to the home.

An audit by the Inspector of completed annual physical examinations was conducted for one resident per Attending Physician in the home and revealed four of four, or 100 per cent of the residents reviewed did not have an annual physical examination completed within one year of the previously completed annual physical examination.

The DOC and the Administrator confirmed to the Inspector that it was the expectation of the home that admission and annual physical examinations were to be completed by the Attending Physicians. They added that in the case of the two cited admission examinations and the four cited annual examinations, the home was not in compliance and should have been. [s. 82. (1) (a)]

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 either a physician or a registered nurse in the extended class, conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 83. Agreement with attending physician

Where a written agreement between a licensee and a physician is required under subsection 82 (4), the agreement must provide for, at a minimum,
(a) the term of the agreement;
(b) the responsibilities of the licensee; and
(c) the responsibilities or duties of the physician, including,
(i) accountability to the Medical Director for meeting the home's policies, procedures and protocols for medical services,
(ii) provision of medical services, and
(iii) provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 83.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written agreement between the licensee and the Attending Physician that provided for:
(a) the term of the agreement,
(b) the responsibilities of the licensee, and
(c) the responsibilities of the Attending Physician, including,
i. accountability to the Medical Director for meeting the home's policies, procedures and protocols for medical services,
ii. provision of medical services, and
iii. provision of after-hours coverage and on-call coverage.

A complaint was received by the MOHLTC on May 6, 2015, citing that resident health concerns were potentially not being followed up.

The DOC stated to Inspector #609 that there were four active attending physicians for the home.

The home was unable to provide any of the four requested written agreements between the licensee and the Attending Physicians.

The Inspector reviewed this Regulation with the Administrator and they confirmed that it was the expectation of the home to be in compliance with the Regulation. They confirmed that there were no written agreements with the four Attending Physicians, and that the home was not in compliance with the Regulation and should have been. [s. 83.]

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 where a written agreement between a licensee and a physician is required under subsection 82 (4), the agreement must provide for, at a minimum, (a) the term of the agreement; (b) the responsibilities of the licensee; and (c) the responsibilities or duties of the physician, including, (i) accountability to the Medical Director for meeting the home's policies, procedures and protocols for medical services, (ii) provision of medical services, and (iii) provision of after-hours coverage and on-call coverage, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the policy and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

Inspector #594 reviewed the home's Personal Assistance Services Devices (PASDs) Use of policy #R-42 (last date reviewed February 20, 2013) which identified differences between a PASD and a restraint, as well as the assessment, implementation, monitoring and evaluation, and documentation requirements of the PASDs as part of the restraint program.

In an interview with the Inspector, the DOC indicated that the policy had not been evaluated since 2013. [s. 113. (b)]

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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Inspector #609 observed RPN #102 obtain a glucometer from the upper drawer of the medication cart during their medication pass, and performed a blood glucose reading for a resident. After use, they placed the glucometer into the upper drawer of the medication cart without cleansing.

RPN #102 reported to the Inspector that they shared a glucometer between two residents of the home and that this was common practice.

During a telephone interview with a member of the home's multidisciplinary team, they stated to the Inspector that it was the home's best practice to use a dedicated glucometer for each resident related to infection control.

In an interview with RN #100, they stated that the home had recently implemented the use of a dedicated glucometer for each resident. They also reported that RPN #102 was a part time staff member and was not aware of the changes to the glucometer procedures.

In an interview, RN #100 confirmed to the Inspector that a dedicated glucometer for each resident should be used. They further stated that in the use of a shared glucometer between residents, the home was not in compliance with their infection prevention and control program and should have been. [s. 229. (4)]

2. On November 4, 2015, RN #100 was observed by Inspector #609 to have pulled the privacy curtains of resident #014 in order to provide care to the resident. After care was completed, RN #100 replaced the privacy curtains and left the room holding personal care items used during care. RN #100 did not complete hand hygiene after body fluid exposure risk or after leaving the resident's environment after touching the resident.

A review of the home's Hand Hygiene policy #IC-116 indicated that staff were to perform hand hygiene after body fluid exposure risk and after touching a resident or after touching any object in the resident's environment and then leaving the room.

In an interview RN #100 confirmed it was the expectation of the home that after body fluid exposure risk and/or leaving the resident's environment after touching a resident, hand hygiene would be required. They stated that in their contact with resident #014 this did not occur and should have. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

A family member stated to Inspector #609 that a private space was unavailable to meet with the resident, as they occupied a shared room. Inspector #616 observed the resident home areas which were accessible to all residents that included the dining room, the activity room, and the lounge. Residents resided in either shared rooms with one other resident, or private rooms.

Inspector #616 met with a multidisciplinary team member and RN #104 who both stated there was not a private space within the home for residents to meet. The DOC also stated there was no private meeting space available to residents to access without interference. [s. 3. (1) 14.]

WN #12: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and preferences of that resident.

A review of the oral hygiene plan of care for resident #005 revealed oral care was to be performed with a specific frequency and as needed (PRN).

A review of the health record revealed that resident #005 consistently refused oral care at a specific time.

An interview with resident #005 revealed when they preferred to receive their oral care.

RPN #107 stated to the Inspector that resident #005 consistently refused oral care at a specific time. RPN #107 confirmed that it was the expectation of the home that the plan of care was based on the needs and preferences of the resident. They further added that the plan of care was not based on the oral care preferences of this resident and should have been. [s. 6. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints received by the long-term care home concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

Inspector #616 reviewed the home's complaint records from January 1-November 11, 2015, provided by the DOC. A written complaint related to quality of resident care was received by the home. There was no record on the Complaint Documentation Form that the written complaint had been forwarded to the Director.

The DOC confirmed to the Inspector that the written complaint had not been forwarded to the Director. [s. 22. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's Staffing Plan policy (last revised June 5, 2015), indicated that there would be an annual written record of the evaluation of the staffing plan.

An interview with the DOC revealed an annual evaluation of the staffing plan had not been completed.

A review of the Regulation was conducted with the DOC and they confirmed that it was the home's expectation to be in compliance with the Regulation. They added that the written annual evaluation of the staffing plan for the home had not been completed and the home was not in compliance with the Regulation, or the home's own policy and should have been. [s. 31. (4)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, which included hygiene care and grooming, on a daily basis.

On November 3, 2015, resident #003 was observed with facial hair.

Inspector #594 interviewed PSW #103 and RN #104 who indicated that the resident’s facial hair should be removed. In an interview with the Substitute Decision Maker of resident #003, it was indicated the resident would prefer to have their facial hair removed.

The inspector reviewed the resident’s plan of care which failed to identify hygiene and grooming care related to their facial hair. [s. 32.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the health record for resident #005 revealed an area of altered skin integrity.

A review of the health record revealed a weekly wound assessment had been completed with a two week gap between assessments. A further six week gap in assessment completion was noted by the Inspector.

An interview with the DOC confirmed that the it was the expectation of the home that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, would have been reassessed at least weekly by a member of the registered nursing staff. They stated that for the two week, and six week gap in weekly wound assessments of resident #005, the home was not in compliance with the Regulation and should have been. [s. 50. (2) (b) (iv)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee had responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Resident Council meeting minutes revealed that resident #004 brought concerns forward related to disrepair of a fixture.

Interviews with residents #004 and #006 revealed no response, written or otherwise, was provided to the council related to the disrepair of the fixture.

An interview with the DOC confirmed they had not responded in writing to the concern raised in Resident Council by resident #004. They confirmed that it was the expectation of the home that a written response related to concerns or recommendations received from the Resident Council was to be made within 10 days, and that in the case of the concern received by the home from resident #004, the home did not respond within 10 days and should have. [s. 57. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home’s Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as of January 1, 2011, the DONPC (Director of Nursing and Personal Care) worked regularly in that position on site for at least the following amount of time per week:

3. In a home with 30 to 39 licensed beds, at least 16 hours

A complaint was received by the MOHLTC on May 6, 2015, citing that it was difficult to find staff in the home.

An interview with the Administrator revealed that the home has a licensed bed capacity of 33 beds and the DOC and ADOC equally share the role of DONPC and the required 16 hours per week.

A review of the DONPC coverage between October 12, 2015, to October 30, 2015, revealed that for 1 of the 3 weeks reviewed, the DOC/ADOC did not provide the required 16 hours of work in the DONPC position on site at the home.

An interview with the Administrator and the ADOC confirmed that for the week of October 12, 2015 to October 16, 2015, the DOC covered 10 hours of the required 16 hours.

A review of the Regulation was conducted with the Administrator who confirmed that it was the expectation of the home to be in compliance with the Regulation. They added that in the case of insufficient coverage provided by the DOC/ADOC for the week of October 12-16, 2015, the home was not in compliance with the Regulation and should have been. [s. 213. (1)]

Issued on this 15th day of January, 2016

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

Original report signed by the inspector.

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER KOSS (616), CHAD CAMPS (609), MONIKA GRAY (594)

Inspection No. / No de l'inspection : 2015_401616_0019

Log No. / Registre no: 029572-15

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 15, 2016

Licensee / Titulaire de permis : THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET, P.O. BOX4000, COCHRANE, ON, P0L-1C0

LTC Home / Foyer de SLD : VILLA MINTO
241 EIGHTH STREET, P.O. BOX280, COCHRANE, ON, P0L-1C0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paul Chatelain

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To THE LADY MINTO HOSPITAL AT COCHRANE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_380593_0001, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee is ordered to ensure that the Policy #LTC-630 Zero Tolerance of Abuse and Neglect (review date December 5, 2012) is in compliance with applicable requirements under the Act specifically related to the following section:

F-Dealing with persons who have abused / neglected or alleged to have abused / neglected

The licensee shall:

1) Review and revise Policy #LTC-630 Zero Tolerance of Abuse and Neglect to ensure that persons who have abused/neglected or alleged to have abused/neglected are immediately suspended or placed in a position that does not allow access to residents, pending the investigation.

2) Provide education to all staff related to the contents of the revised Zero Tolerance of Abuse and Neglect policy by February 5, 2016.

3) Submit a copy of the revised Policy #LTC-630 Zero Tolerance of Abuse and Neglect to Jennifer Koss, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, jennifer.koss@ontario.ca by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of the long-term care home to have, institute or otherwise put in place a policy, the licensee did not ensure that the policy was in compliance with and was implemented in accordance with applicable requirements under the Act, and was complied with.

During a meeting with the DOC, Inspector #616 requested the home's most current policy related to Zero Tolerance of Abuse and Neglect. They provided a binder of current policies titled "Annual Education Villa Minto" for the Inspector's reference. On review of policy #LTC-630 Zero Tolerance of Abuse and Neglect, the last revision date was noted to be December 5th, 2012. The Inspector reviewed the policy with the DOC who confirmed this dated copy was the most up to date.

Within the current policy, section F – Dealing with Persons who have abused/neglected or alleged to have abused/neglected residents, remained unchanged after a Compliance Order #003 was issued in inspection #2015_380593_0020 served April 27, 2015. The licensee was ordered to review and ensure by April 30, 2015, that the policy directed that persons who have abused/neglected or alleged to have abused/neglected are immediately suspended or placed in a position that does not allow access to residents, pending the investigation.

The current policy, unchanged, allowed for staff members who have abused or alleged to have abused a resident, to continue to work in the home providing direct care during the investigation and pending the determination of the allegations to be factual.

This policy does not meet the requirements of section 20 under the LTCHA, 2007.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s. 8 (1) have been previously identified under inspection report 2015_380593_0020 including a compliance order served April 27, 2015; and inspection report 2014_281542_0014 including a compliance order served July 3, 2014.

The decision to re-issue this compliance order was based on the scope which

could have widespread affect; the severity which indicated a potential for actual harm and the compliance history, which despite two previous compliance orders, has continued with this area of the legislation. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of January, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Jennifer Koss

Service Area Office / Bureau régional de services : Sudbury Service Area Office