Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 10, 2016	2016_428628_0007	000195-15	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

MARIE LAFRAMBOISE (628)

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): May 16, 17, 18, 19 and 20, 2016

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and annual program evaluation records.

This Critical Incident System inspection was related to disease outbreak reporting, fall prevention and staff to resident abuse concerns.

A Complaint inspection #2016_428628_0011 and a follow-up inspection #2016_428628_0010 were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Resident Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aides, Rehabilitation Coordinator, Activity Coordinator, Manager of Administration and residents and their family members.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstance of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

On May 17, 2016, Inspector #628 reviewed the Critical Incident System (CIS) report which documented that a respiratory outbreak was declared by the Public Health in January 2015, and was submitted to the Director three days later by the home. The inspector verified that no other record of contact to the Director was made during these dates.

On May 17, 2016, Inspector #628 interviewed the ADOC who stated that the reason the home delayed reporting to the Director was that the home was waiting to receive the identity of the outbreak organism by the lab which was completed three days after the outbreak had been declared. The ADOC confirmed that the home was late reporting the outbreak to the Director and did not report immediately when the outbreak had been declared on a particular day in 2015 and should have. [s. 107. (1)]

Issued on this 7th day of July, 2016

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

Original report signed by the inspector.