Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 5, 2021	2021_668543_0010	004832-21	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

TIFFANY BOUCHER (543)

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): April 19-22, 2021.

The following intake was inspected upon during this Complaint inspection:

-one complaint submitted to the Director regarding the admission of a resident without the authorized approval of the placement coordinator.

A Critical Incident System inspection #2021_668543_0011, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Placement Admissions Coordinator with the North East Local Health Integration Network (NELHIN), Infection Prevention and Control (IPAC) Lead, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed infection control practices, reviewed relevant health care records, internal investigation notes, as well as policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 49. A licensee of a long-term care home shall not admit a person unless the person's admission to the home is authorized by the placement co-ordinator for the geographic area where the home is located, and shall admit a person whose admission is so authorized. 2007, c. 8, s. 49.

Findings/Faits saillants :

1. The licensee has failed to ensure that they had received authorized approval by the placement co-ordinator prior to admitting a resident to the Long-Term Care Home (LTCH).

A complaint was submitted to the Director regarding a concern that the LTCH had completed an exchange of residents from one LTCH to another, prior to receiving approval from the placement co-ordinator of the North East Local Health Integration Network (NELHIN) and had not followed the admission process.

In an interview with the placement co-ordinator from the NELHIN, they indicated that one resident had been discharged from the home, and another resident was admitted to the home, prior to the authorization from the placement co-ordinator of the NELHIN.

In an interview with the DOC, they verified that the admission process had been completed prior to receiving authorization of the placement co-ordinator from the NELHIN.

Sources: the residents' electronic progress notes and census; MICs group of health services LTCH admission information package,interviews with the Placement Co-ordinator at the NELHIN and the DOC. [s. 49.]

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 ensure that the licensee shall not admit a person unless the person's admission to the home is authorized by the placement co-ordinator for the geographic area where the home is located, and shall admit a person whose admission is so authorized, to be implemented voluntarily.

Issued on this 6th day of May, 2021

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

Original report signed by the inspector.