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: October 16, 2024.
Inspection Number: 2024-1302-0001
Inspection Type:
Critical Incident

Licensee: The Lady Minto Hospital at Cochrane
Long Term Care Home and City: Villa Minto, Cochrane

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):

October 7-11, 2024.

The following intake(s) were inspected:

- Intake: related to potential improper/ incompetent care of a resident by staff.
- Intake: related to a fall of a resident which resulted in an injury.
- Intake: related to an outbreak in the home.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure a resident was treated with courtesy and respect from a Personal Support worker (PSW) who had made comments while providing care on specific dates.

Sources: Review of critical intake; review of specific reports; a specific letter for the PSW; interviews with staff members.

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee had failed to immediately report to the Director specific incidents, that involved a specific PSW, that alleged improper care, which resulted in a risk of harm to a resident.

Sources: Review of critical intake; review of the specific reports; a specific letter for the PSW; policy titled, Duty to Report; and interviews with staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure a documented record was kept, of the complaints submitted for a specific resident, that identified care concerns.

Sources: Review of a critical intake; review of the specific reports; review of progress notes for the resident; a specific letter for the PSW; policy titled, Managing and Reporting Complaints; interviews with staff.