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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: October 9, 2025
Inspection Number: 2025-1302-0002
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 dates: October 6-9, 2025

The following intakes were inspected:
- One intake related to an infectious disease outbreak.
- One intake related to allegations of resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments.

When a resident expressed responsive behaviours toward another resident, the required assessments, referrals, and care plan reviews and revisions, were not completed.

Sources: Resident health records, interviews with staff, the home's policy 'Responsive Behaviours Program'.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that when residents were in isolation due to an infection, their symptoms were monitored every shift.

Sources: Resident progress notes, outbreak records; and interview with the home's Infection Prevention and Control Lead.

WRITTEN NOTIFICATION: Notification re: incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident,

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision maker was notified of an allegation of abuse.

When an incident of resident to resident abuse occurred, their substitute decision maker was not notified.

Sources: Resident progress notes, the home's incident report, interviews with staff.

WRITTEN NOTIFICATION: Police notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of an allegation of abuse of a resident that may constitute a criminal offence.

When a resident made threats to another resident, the police were not notified.

Sources: Resident progress notes, Critical Incident (CI) report, interview with staff.

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