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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 23, 2015	2015_280541_0020	O-002091-15	Resident Quality Inspection

Licensee/Titulaire de permis

CENTENNIAL PLACE MILLBROOK INC.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

Long-Term Care Home/Foyer de soins de longue durée

CENTENNIAL PLACE LONG-TERM CARE HOME
2 Centennial Lane North MILLBROOK ON M5J 2G2

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

AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)

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): June 8-12, and June 15-16, 2015

The following inspections were conducted concurrently with the RQI: O-002055-15, O-001267-14, O-001900-15 and O-000516-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses, the RAI Coordinator, the Life Enrichment Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, Resident Council President, Residents and Family members.
In addition, Inspectors reviewed resident health care records, observed staff to resident interaction, observed lunch meal service, observed medication administration, reviewed relevant meeting minutes, reviewed staffing schedule for registered staff members and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

5 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCH 2007, s. 24 (1)2 whereby the licensee did not ensure that an incident of abuse or neglect of a resident that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

Re: Log #O-000516-14
A Critical Incident was submitted on a specified date related to an incident of Abuse/Neglect. Resident #41 had an order for the application of a specific medication patch to be applied. On four specified dates, the home was able to ascertain that sometime between these doses, the Resident's medication patch had been removed and replaced with another used medication patch. The home could not verify how or when the switch had occurred and as the internal investigation progressed, the alterations that were being made to the medication patch for Resident #41 suddenly ceased.

In an interview on June 16, 2015, the ADOC and the Administrator confirmed that the home had reasonable grounds to suspect that abuse or neglect of Resident #41 had occurred by the fourth incident of the medication patch removal on a specified date. The home had immediately initiated their internal investigation but Critical Incident #2903-000004-14 was not submitted to the Director until two days following the identification of suspected abuse or neglect.

Re: Log #O-001900-15
A Critical Incident was submitted on a specified date related to another incident of Abuse/Neglect. Resident #41 had an order for the application of a specific medication patch to be applied. On four specified dates, nursing staff discovered that the medication patch applied to Resident #41 was missing. The home immediately initiated another internal investigation that resulted in police involvement and the termination of a staff member.

In an interview on June 16, 2014 the DOC and the Administrator confirmed that the home had reasonable grounds to suspect that abuse or neglect of Resident #41 had occurred by the third incident of the missing medication patch on a specified date but the Critical Incident report was not submitted to the Director until three days later. [s. 24. (1)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of the satisfaction were documented and made available to the Residents' Council to seek their advice about the results and the actions taken to improve the long-term care home, and the care, services, programs based on the results of the survey.

On June 11, 2015 during an interview with Resident #44 it was confirmed that the Residents' Council was not provided with the results of the satisfaction survey to seek the Councils' input with respect to the results and actions taken to improve the home based on the results.

On June 11, 2015 the Life Enrichment Coordinator was interviewed and confirmed that the Residents' Council was not provided with documented results of the satisfaction survey and the actions taken to improve the long-term care home based on the results.

On June 11, 2015 during an interview with the Administrator she confirmed that the home did not seek the advice of the Residents' Council in acting on the results of the survey. However the Administrator stated this issue had been identified and a plan implemented to provide documentation of the survey results and seek the advice of the Residents' Council. [s. 85. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (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,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(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. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.

Re: Log #O-000516-14

On four specified dates the home was able to ascertain that the medication patch applied to Resident #41 had been removed and replaced with another patch. The home could not verify how the switch had occurred and as the internal investigation progressed, the alterations made to the medication patch for Resident #41 ceased.

In an interview on June 16, 2015, the ADOC and the Administrator confirmed that the home had reasonable grounds to suspect that abuse or neglect of Resident #41 had occurred by the fourth incident of the medication patch removal on a specified date. The home had immediately initiated their internal investigation but the POA of Resident #41 was not notified until two days later.[s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force 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. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Re: Log #O-000516-14

On four specified dates, the home was able to ascertain that the medication patch applied to Resident #41 had been removed and replaced with another patch. The home could not verify how the switch had occurred and as the internal investigation progressed, the alterations made to the medication patch for Resident #41 ceased.

In an interview on June 16, 2015, the ADOC and the Administrator confirmed that the home had reasonable grounds to suspect that abuse or neglect of Resident #41 had occurred by the fourth incident of the medication patch removal on a specified date. The home had immediately initiated their internal investigation but the police were not notified until two days later.

Re: Log #O-001900-15

On four specified dates, the medication patch applied to Resident #41 was missing. The home immediately initiated another internal investigation that resulted in police involvement and the termination of a staff member.

In an interview on June 16, 2014 the DOC and the Administrator confirmed that the home had reasonable grounds to suspect that abuse or neglect of Resident #41 had occurred by the third incident of the missing medication patch on a specified date but the police were not notified until three days later. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Re: Log #O-000516-14

A Critical Incident was submitted on a specified date related to an incident of Abuse/Neglect. Resident #41 had an order for the application of a medication patch. On four specified dates, the home was able to ascertain that sometime between these doses, the Resident's medication patch had been removed and replaced with another used medication patch. The Resident did not receive the doses of medication as specified by the prescriber.

In an interview on June 16, 2015, the ADOC and the Administrator confirmed that Resident #41 did not receive the dose of medication from the medication patch as specified by the prescriber on four specified dates.

Re: Log #O-001900-15
A Critical Incident was submitted on a specified date related to another incident of Abuse/Neglect. Resident #41 had an order for the application of a medication patch. On four specified dates nursing staff discovered that the medication patch applied to Resident #41 was missing. The Resident did not receive the doses of medication as specified by the prescriber.

In an interview on June 16, 2014 the DOC and the Administrator confirmed that Resident #41 did not receive the dose of medication from the medication patch as specified by the prescriber on the four specified dates. [s. 131. (2)]

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Issued on this 23rd day of June, 2015

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

Original report signed by the inspector.