



**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 rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2017	2017_623626_0005	007331-17	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

DENISE BROWN (626), SAMI JAROUR (570)

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): April 19, 20, 21, 24, 25 and 26, 2017

The following Intake Logs were inspected during the course of the Resident Quality Inspection:

Critical Incident Logs



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**Intake Log #000204-17: Related to an alleged resident to resident physical abuse
Intake Log #006036-17: Related to fall resulting in injury**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Director of Resident and Family services, Pharmacists, Pharmacy Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Resident Council Representative.

During the inspection, the inspectors, toured the resident home areas, observed staff to resident provision of care, resident to resident interactions, infection control practices and medication administration. The inspectors reviewed residents' health records, internal related investigations, applicable policies, Resident Council minutes, Family Education Night agenda and Critical Incidents.

The following policies and procedures were reviewed:

Admission Checklist-PSW, Personal Items and Aids, Falls Prevention and Management Program, Falls Prevention Committee, Falls Risk Assessments and Interventions, Responding to Resident Falls, Responsive Behaviours-Overview, Aggressive or Violent Behaviours, Responsive Behaviour Screening and Assessments, Abuse and Neglect – Zero Tolerance, Abuse of Residents, Abuse and Neglect – Training and Education, Abuse and Neglect – Communication, Abuse and Neglect – Investigation, Abuse and Neglect – External Reporting, Skin and Wound Care Program, Nutrition and Hydration Program, Dietitian Referrals, Meals Documentation, Resident Weights and PCC Documentation – Dietary.

The following Inspection Protocols were used during this inspection:



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**Accommodation Services - Housekeeping
Contenance Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care**

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

**2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6.
Plan of care**



Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident; 2007, c. 8, s. 6 (1).

(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).

(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that set out, the planned care for the resident.

Resident #007 was admitted to the home on a specified date. The review of the resident's health records revealed that the resident have multiple diagnoses. Resident #007 has had four falls over the last year.

A review of the resident's plan of care did not indicate the use of a Hi-Lo bed in the lowest position when the resident is in bed, as an intervention for falls prevention. The current written plan of care also indicated several other interventions for fall prevention.

In an interview and combined review of resident #007's plan of care, RPN #120 indicated that as part of the resident's plan of care, the bed is to be left in the lowest position but this information was not written in the plan of care. Personal support workers (PSW) #113 and #130 both indicated that the resident's bed should be in lowest position.

During an interview in April, 2017 with RN#114, who is the Falls Committee lead, it was indicated that all the beds in the home are Hi-Lo beds and that placing resident #007's bed in the lowest position, should have been written in resident's plan of care. In another interview on the same day, the DOC confirmed that all the beds in the home are Hi-Lo



beds and that placing resident #007's bed in the lowest position should have been written in resident's plan of care.

The licensee failed to ensure that the written plan of care for resident #007 set out the planned care for the resident, specific to the Hi-Lo bed in the lowest position as a falls prevention intervention. [s. 6. (1) (a)]

2. The licensee has failed to ensure that when the resident is reassessed, the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #016 was admitted to the home on a specified date with several medical diagnoses. Upon admission, the resident had used a specific mobility device with a specified positioning capacity and a restraining device.

On April 24, 2017, Inspector #570 observed resident #016 sitting in the mobility device with the positioning feature engaged. The inspector also noted that another specified device with restraining effect was attached to the mobility device. The restraint device was not in use at the time of the observation.

Review of the current of plan of care for resident #016 indicated an intervention to use safety devices, such as the mobility device with positioning capacity and the specified restraining device.

In April, 2017 during interview with RPN#116 and PSW #117, who both indicated to the inspector, that the resident does not use any restraining devices and only use a mobility device as a personal assistive service device (PASD). RPN #116 indicated to the inspector, that staff do not apply the restraining device in the home and that the resident's substitute decision maker (SDM) uses the restraining device, when taking the resident outside the home. RPN #116 indicated, that the intervention related to the application of the restraining device when in the mobility device as indicated in the plan of care, does not reflect what the staff were actually doing.

During an interview in April, 2017 with the MDS RAI coordinator RN #114, who indicated to the inspector that registered staff usually update the plans of care and that she oversees this process. In the same interview RN #114, also indicated that the plan of care for resident #016 relating to the use of the restraint, should have been removed as the resident does not use this device.



Therefore, when the resident was reassessed and the plan of care reviewed, it was not revised when the resident's care needs changed, or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).

(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the tour of the home on a specified date in April, 2017, the following unlabelled items were observed in these specific locations:

Trail House Spa Room contained Kenra Moisturizing Conditioner, Softsoap Acai-Berry and Tropical Water Body Wash, Soft Soap Sweet Honeysuckle and Orange Peel Body Wash. Personal Support Worker #104 identified, the unlabelled items as belonging to a resident and removed the items from the room. The PSW also indicated that the personal items should have been labelled. The PSW divulged that the resident was showered and the personal items were left behind in the Spa room.

Trail House Shower Room contained, Dove Men's Care Face and Body Wash, Dove Men's Care Shampoo and Conditioner, Old Spice Body Wash, Old Spice Deodorant, Secret Deodorant, all of these items were in an unlabelled purple basket which was located on the counter.



Harvest House Spa Room contained, Speed Stick Deodorant, Zone Shower Gel, Pantene Conditioner, Willows and Bloom Shower Gel and Willows and Bloom Lotion. Personal Support Worker #105 identified the unlabelled items and home stock items in order to differentiate resident specific personal items. Personal Support Worker #105, indicated that the personal items should have been taken back to the residents' rooms. Personal Support Worker #105 also indicated an awareness of the requirement of the external use sticker being applied to personal items and lack of awareness that resident specific personal item are to be labelled with the resident's name.

In three separate interviews on a specified date in April, 2017 with PSW #111, #112, and #113, all PSWs indicated that the personal items of resident should be labelled with the resident's name. The PSWs all indicated that the education pertaining to the labeling of personal items is provided on hire.

An interview with ADOC on s specified date in April, 2017, confirmed that education on labeling personal items is provided to staff on hire. Another interview with the DOC on the same day also indicated that education is provided to staff on hire.

The licensee failed to label resident specific personal items when newly acquired. [s. 37. (1) (a)]

Issued on this 17th day of May, 2017

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

Original report signed by the inspector.