Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Sep 21, 2021	2021_861194_0009	005478-21, 006739-21	Critical Incident System

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 L0A 1G0

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 3, 4, 5, 6, 9, 10, 23, 2021

Critical incident inspections related to resident to resident physical abuse and a resident fall.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Administration staff, Covid-19 Screener and Housekeeping staff.

During the course of the inspection the inspector observed staff to resident provision of care, infection control practices, air temperatures in designated cooling areas and medication administration. The inspector reviewed clinical health records of identified residents, Covid-19 visiting policy "IPC-H-50, Covid-19 screening and testing logs,

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- 3 WN(s)
- 2 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 O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature in the home was maintained at a minimum of 22 degrees Celsius.

The Administrator confirmed that the designated cooling areas in the home were the Heritage and Harvest dining rooms, as well as the back-Dens on all four units. Review of the Room Temperature Logs, for the period of August 3 to 9, 2021 confirmed 38 documented air temperatures, below 22 degrees Celsius. Observations by Inspector #194 for the period of August 4 to 9, 2021 confirmed 10 air temperatures, below 22 degrees Celsius in the back-Den areas of the home. RPN #109 confirmed that they had taken the air temperature in the back-Den and that the temperature was 21 degrees Celsius. The RPN stated that if the temperature was below 20 degrees Celsius or above 25 degrees Celsius, they would report it to their supervisor. RPN #120 confirmed that temperature in the back-Den had been measured at 21 degrees Celsius, which was ok and no action was taken. Failing to maintain the air temperature at the home at a minimum of 22 degrees Celsius, increases the risk of residents being uncomfortable.

Sources: Observation of the temperatures at the home by Inspector, review of air temperature logs and interview with staff (Administrator, RPN #120 and #109) [s. 21.]

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 by ensuring that the air temperature in the home is maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the Infection Prevention and Control program, related to Hand Hygiene (HH), when residents were not offered or provided HH post meals.

A PSW was observed providing a snack to three residents, no hand hygiene (HH) was offered or provided. Two other PSW's were observed assisting two residents out of the dining room, no hand hygiene was offered or provided. A PSW stated that HH was provided to the resident prior to meals in their rooms, and provided to resident post meal if their hands were sticky. Two PSW's stated that HH was provided to residents in their rooms prior to meals and post meal using the wipes, for the residents with sticky hands. DOC confirmed that the home had a Hand Hygiene program in place at the home and that hand hygiene should be provided or offered to residents prior to and post meals and activities. Failing to ensure that residents are provided HH post meals increases the potential for infection.

Sources: observation of meals, Interview with PSW staff and DOC (PSW #111, 118, 110, 123 and 128). [s. 229. (4)]

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 by ensuring that staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that is secure and locked.

Inspector observed a medication cart, unattended and unlocked in the resident hallway. An RPN was assisting a resident with care in a resident room. RPN stated that they usually have the medication cart locked. On another day, a medication cart was observed, unattended and unlocked in front of the dining room. Another RPN was located in the nursing station behind the closed door. Failing to lock the medication cart in a resident care area, increases the potential for residents accessing medications.

Sources: observation of medication administration and interview with staff. (RPN #100, #122). [s. 129. (1) (a)]

Issued on this 23rd day of September, 2021

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

Original report signed by the inspector.