Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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_0008	003170-21	Complaint

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 Complaint inspection.

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

A complaint related to resident care was completed.

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), Essential Care Visitor (ECV), Security Guard (SG), Physician and Registered Dietitian.

During the course of the inspection, the inspector observed meal service, staff to resident provision of care and medication administration. The inspector reviewed the identified resident's clinical health record, complaint process, Nutritional assessments, PSW staffing and back up plans, skin and wound, medication, care conference and weight records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care related to night checks were completed.

Video footage of a resident on the floor was provided to the Ministry. The video confirms that the resident was on the floor for an extended amount of time with no staff checking on the resident. The resident is noted to be unable to get up off the floor as well as sleeping on the floor.

The Administrator confirmed that they were aware of the incident. The incident had been investigated at the home and it was determined that there had been miscommunication between the care providers related to who was going to check on the resident. As a result, the resident was on the floor for several hours. Failing to provide regular checks during the night increases the risk of injury.

Sources: Video from resident's room camera, Interview with (Administrator) [s. 6. (7)]

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 resident's care is provided as specified in the plan of care, related to night checks, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that safe positioning techniques were used when assisting the resident.

Video footage and photo of a resident sitting in their chair in the dining room was provided to the Ministry. The photo, shows the resident asleep, sliding down the chair as well as leaning to the left with their arm hanging over the chair touching the floor. Corresponding video shows the resident being asked to wake up by someone. The video does not show any assistance or aides being provided for the resident for repositioning. Failing to ensure safe positioning techniques increases the risk of pain and potential injury.

Sources: video and photo of the resident, Interview with (POA) [s. 36.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

A residents food was provided and an RPN assisted resident with their meal 10 minutes later. Another RPN confirmed the resident required one-person physical assistance with meals. Another resident was provided food and a PSW staff assisted the resident 10 minutes later. The resident's clinical health records confirmed that the residents required one-person physical assistance with meals. Failing to provide assistance to residents at meals, when food is served, decreases the enjoyment of meals being consumed by the resident.

Sources: observation of meals, review of clinical health records and interview with staff (RPN # 126)The licensee has failed to ensure that [s. 73. (2) (b)]

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.