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**

**Division de la responsabilisation et de la performance du système de santé**
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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 |
|---|---|---|---|
| Feb 13, 2014 | 2014_031194_0005 | O-000086-14 | 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**

CHANTAL LAFRENIERE (194), LYNDA BROWN (111), PATRICIA POWERS (157)

**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): February 4, 6,7 & 10, 2014

During the course of the inspection a Critical Incident Log# 000360-13 and Complaint Log# 001049-13 were inspected concurrently

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC),Assistant Director of Care (ADOC), Infection Control Nurse (ICN),Registered Nurse (RN), Registered Practical Nurse (RPN),Personal Support Worker (PSW), RAI Co-ordinator, Dietitian, Recreation Supervisor, Family Support Supervisor, Residents and Family members.

During the course of the inspection, the inspector(s) completed an initial tour of the building, observed Meal Service in Dining Areas, observed Medication Administration and Medication Storage Areas,reviewed clinical health records of identified Residents, Licensee's policies for "Resident Council" GA-B-40,"Family Council" GA-B-44,"Responsive Behaviour-Overview" GA-A-50,"Aggressive and Violent Behaviours" GA-A-55,"Responsive Behaviour Screening & Assessments" RS-I-30,"Pieces Assessment Protocol" RS-I-32,"Responsive Behaviour Referrals" RS-I-35,"Falls Prevention & Management Program" RS-I-20, "Falls Risk Assessments and Interventions" RS-I-22,"Responding to Resident Falls" RS-I-24, Food Council Committee Minutes, Immunization records for residents and staff and Critical Incidents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 care set out in the plan of care was provided to the resident as specified in the plan related to a prescribed treatment.

Review of Resident #13 physician orders indicated the resident was to receive daily prescribed treatments at specified times.

Review of Resident #13 electronic medication administration records (e-MARS) and progress notes indicated there were 8 days when the prescribed treatment was not completed.

The licensee did not provide care as specified, putting the resident at risk when the prescribed treatment was not completed to support the assessment required to determine the administration of the prescribed medication.(111) [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 ensuring that the care set out in the plan of care for residents related to prescribed treatments are provided as specified in the plan, to be implemented voluntarily.***

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**WN #2: 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).**

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**Findings/Faits saillants :**

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

Review of Resident #13 physician orders indicated the resident was to receive medication based on a prescribed treatment.

Observation of RPN #111 on an identified date indicated the prescribed treatment was completed for resident #13 as ordered but the drug was not administered in accordance with the directions.

Review of Resident #13 e-MARS for a two month period for the prescribed drug indicated the resident did not receive the drug on 7 separate times as specified by the prescriber(111) [s. 131. (2)]

***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 drugs are administered to resident#3 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**Issued on this 21st day of February, 2014**

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

Chantal Lafreniere (194)
Pat Powers (157)
Lynda Brown (~~#~~111)
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