



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2017	2017_565612_0009	028271-16, 028649-16, 029501-16, 030932-16, 004457-17, 005476-17	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

SARAH CHARETTE (612)

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): April 3-7, 2017.

This Critical Incident System Inspection is related to three Critical Incident (CI) reports the home submitted to the Director related to resident to resident abuse and three CI reports related to staff to resident abuse.

A Complaint Inspection #2017_565612_0008 was conducted concurrently to this inspection. Findings of non-compliance for LTCHA, s. 20 (1) from this inspection were issued in that report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident and resident to resident interactions, reviewed residents' health care records, staffing schedules, policies, procedures, programs, and staff personnel files.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an



individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Inspector #612 reviewed a Critical Incident (CI) report submitted to the Director on a specific date in February, 2017. The CI report described that PSW #102 did not provide care to resident #004, #005 and #006 during a specific shift.

On April 4, 2017, Inspector #612 interviewed PSW #114. They stated that when they arrived for their shift on a specific date in February, 2017, PSW #102 made a specific comment in regards to resident #004's continence care. PSW #114 then stated when they went to provide care to resident #004, they observed that specific incontinence care had not been provided to the resident. They also observed that specific incontinence care was not provided to resident #005 and #006.

Inspector #612 reviewed resident #004, #005 and #006's individualized plans to promote and manage bowel and bladder continence that were in place on the specific date in February, 2017. Resident #004, #005 and #006's care plans identified specific interventions including the level of assistance the resident required and the frequency the assistance was required.

On April 4, 2017, Inspector #612 interviewed RPN #111. They stated that on the specific shift in February, 2017, PSW #114 had reported to them that resident #004, #005 and #006 did not have specific incontinence care provided as specified in the care plan. They reported that they had provided specific instructions, which were included in resident #006's care plan to follow and with the resident's increased incontinence, the resident was at higher risk for skin breakdown and other complications. RPN #111 stated that the incontinent care should have been provided to resident #004, #005 and #006 during the shift, as indicated in their care plan.

Inspector #612 reviewed the investigation notes provided by the DOC. PSW #102 was interviewed by the DOC and Administrator. PSW #102 stated that they had not provided care during the specific shift to resident #004 as they were sleeping soundly. PSW #102 stated that resident #005 had refused assistance from them with their continence care. PSW #102 stated that they had not provided continence care to resident #006 at a specific time as the resident was sound asleep.

On April 6, 2017, Inspector #612 interviewed the DOC. The DOC stated that the staff were expected to follow the care plans and implement the care plan to manage



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continence. The DOC confirmed that PSW #102 had not provided incontinent care as per the plan of care to resident #004, #005 and #006. [s. 51. (2) (b)]

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 to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

Issued on this 12th day of May, 2017

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

Original report signed by the inspector.