Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 2, 3, 9, 10, 14, 2011	2011_099188_0027	Follow up

Licensee/Titulaire de permis

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT
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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing Staff, Personal Support Workers, restorative care staff, the RAI coordinator and residents

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records and various policies and procedures

The following Inspection Protocols were used during this inspection:

Medication

Pain

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Inspector reviewed the plan of care for a resident. Inspector noted that the plan of care does not include any direction related to transferring. Inspector reviewed the plan of care with a PSW and the RAI Co-ordinator. Each staff member confirmed to the inspector that no direction is provided related to transferring the resident. Both staff members reported that it should provide directions to staff on the resident's transferring abilities. Inspector spoke with a PSW on the unit who was aware of the resident's transferring abilities. This information is not included in the plan of care for the resident. The licensee failed to ensure that the plan of care provides clear directions to staff and others who provide direct care related to the amount of assistance required by the resident for transferring. [LTCHA 2007, S.O. 2007, c.8, 6(1)(c)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. Inspector spoke with the Administrator, Carol McIlveen, on November 4, 2011. Inspector inquired if the home has 24 hour Registered Nurse (RN) coverage. McIlveen reported that the home does not currently have 24 hour RN coverage. McIlveen reported that RN coverage is currently available on the 12 hour night shift but not on the 12 hour day shift. The licensee failed to ensure that a RN who is both an employee of the home and a member of the regular nursing staff is on duty and present in the home at all times. [LTCHA 2007, S.O. 2007, c.8, s.8(3)]

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 a registered nurse, who is both an employee of the home and a member of the regular nursing staff is on duty and present in the home at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following subsections:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;
(b) attends regularly at the home to provide services, including assessments; and
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. Inspector spoke with an RPN to inquire if the residents annual physical exam would be kept somewhere other than the resident's chart. This RPN identified that the home is behind on physical exams completed. The RPN reviewed the list of outstanding physical exams and noted that two identified residents are on the list as requiring their physical exams. Inspector noted that the list identified ten residents requiring physical exams, including new admission physical exams and annual physical exams. The licensee failed to ensure that either a physician or a registered nurse in the extended class, conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination. [O.Reg. 79/10, s.82(1)(a)]
2. Inspector reviewed the health care record of an identified resident. Inspector noted that the last physical examination completed by a physician was more than a year prior. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts an annual physical examination annually and produces a written report of the findings of the examination. [O.Reg. 79/10, s.82(1)(a)]
3. Inspector reviewed the health care record of an identified resident. Inspector noted that the last physical examination completed by a registered nurse in the extended class was completed a year and a half prior. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts an annual physical examination annually and produces a written report of the findings of the examination. [O.Reg. 79/10, s.82(1)(a)]
4. Inspector reviewed the health care record of an identified resident. Inspector noted that the last physical examination completed by a registered nurse in the extended class was a year and a half prior. The licensee failed to ensure that either a physician or a registered nurse in the extended class conducts an annual physical examination annually and produces a written report of the findings of the examination. [O.Reg. 79/10, s.82(1)(a)]

Issued on this 14th day of November, 2011

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

Ontario

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Name of Inspector/Nom de l'inspecteur ou des inspecteurs
Melissa Chisholm (#188)

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O. Reg. 79/10, s.52(2)	CO-001	2011_188_9553_25Feb151425	188
O. Reg. 79/10, s.8(1)	CO-002	2011_188_9553_25Feb151425	188
O. Reg. 79/10, s.36	CO-003	2011_188_9553_25Feb151425	188
O. Reg. 79/10, s. 131(1)	CO-001	2011_188_9553_25Feb151439	188

Issued on this 10th day of November, 2011

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