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
May 29, 2013	2013_139163_0013	S-000169-13	Critical Incident System

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

DIANA STENLUND (163)

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): May 8-9, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Nutrition Manager, registered nursing staff, personal support workers (PSWs), and residents.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed Critical Incident documentation, observed staff to resident and resident to resident interactions, reviewed the home's prevention of abuse and neglect policy, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Inspector reviewed a Critical Incident (CI) report that outlines resident to resident abuse. Inspector observed resident #169 and noted that the resident was being monitored by staff approximately every 15 minutes. Inspector reviewed the plan of care including the documentation on resident's #169 monitoring sheet and the care plan document. The monitoring sheet indicated a monitoring frequency of every 15 minutes, however the care plan document indicated monitoring every 30 min. The licensee has not ensured that the plan of care provides clear directions to staff and others who provide direct care to the resident. [s. 6. (1)]

2. Inspector noted documentation in the progress notes (several months previous to the CI involving resident #169) where a staff member reported resident #169 had inappropriately touched them. According to an interview with a supervisory staff person, none of the health care team was made aware of the incident. The licensee has not ensured that staff and others involved in the different aspects of care of the resident, collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4)]

3. Inspector was made aware by direct care staff that there was a suspicion that resident #169 might be able to disconnect their monitoring device in use. Inspector interviewed additional staff and noted not all staff were made aware this was a potential concern. Inspector reviewed the plan of care noting that it did not indicate a concern with the resident possibly being able to disconnect their monitoring device. The licensee has not ensured that staff and others involved in the different aspects of care of the resident, collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4)]

1. Inspector reviewed a CI report that outlines resident to resident abuse. According to the Centralized Intake and Assessment Triage Team (CIATT) documentation and an interview with the home's management, the incident was not reported to the Director until approximately 12 hours after the incident had occurred. The licensee has not ensured that a person who has reasonable grounds to suspect the following has occurred or may occur has immediately reported the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

Issued on this 29th day of May, 2013

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

Diana Stenlund, #163