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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_752627_0022	006799-18	Critical Incident System

Licensee/Titulaire de permis

North Centennial Manor Inc.
2 Kimberly Drive KAPUSKASING ON P5N 1L5

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

North Centennial Manor
2 Kimberly Drive KAPUSKASING ON P5N 1L5

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

SYLVIE BYRNES (627)

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): October 17-18, 2018.

The following intake was inspected during this Critical Incident System (CIS) inspection:

- One log related to a fall.

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

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home policies, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The license has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A critical incident system (CIS) report was submitted to the Director regarding a fall which caused a significant change. The CIS report indicated that resident #001 had an unwitnessed fall that resulted in an injury which caused a significant change to their health condition.

Inspector #627 observed resident #001 in their room, with specific interventions in place.

On a subsequent day, Inspector #627 observed resident #001 in their room, with different interventions in place.

Inspector #627 reviewed resident #001's most recent minimal data set (MDS) assessment and noted that it was indicated that resident #001 had not required specific interventions as observed.

Inspector #627 reviewed resident #001's written care plan in effect at the time of the inspection and failed to identify any direction related to the specific interventions that were observed.

Inspector #627 reviewed the home's policy titled "Nursing Care Plan", dated December 2007, which indicated that "care planning should be updated regularly with any changes in resident status".

Inspector #627 interviewed PSW #101 who stated that the care required for a resident was indicated in the resident's written care plan and the kardex. PSW #101 indicated that the specific interventions were for the resident's comfort. PSW #101 further stated that they were not sure how resident #001 was assessed for the specific interventions; they (PSW #101) had heard it was because of discomfort while taking part in a specific activity.

Inspector #627 interviewed RN #103 who indicated that a resident's care plan was to reflect their current care needs. RN #103 reviewed resident's #001's care plan and acknowledged that the care plan had not been updated to include the specific interventions. RN #103 acknowledged that resident #001's written care plan had not

reflected their current needs.

Inspector #627 interviewed the DOC who stated that resident #001 had a specific intervention for comfort measures and that staff had received training from the Occupational Therapist who had made them aware of when the intervention was to be implemented. The DOC acknowledged that the care plan had not been updated to reflect the resident's current care needs.

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.