Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_680687_0020	005640-19, 012019-19	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

LOVIRIZA CALUZA (687)

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): July 23 to 24, 2019.

The following was inspected during this inspection:
- One intake regarding resident elopement.
- One intake regarding staff to resident improper care.

A Complaint Inspection was conducted concurrently with this Critical Incident System (CIS) inspection.

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

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Safe and Secure Home

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

a) The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 went missing from the home on a specified date.

Inspector #687 identified through resident #001's electronic progress notes that a staff member found the resident in a specified area outside the home on a specified date. The documentation from the resident's electronic progress notes indicated that the home's video surveillance revealed that the resident attempted to leave the home; after numerous attempts of entering the main entrance door code, the resident was observed leaving the building. Fifteen minutes later, the resident was brought back to the home by a staff member.

On a specified date, resident #001's electronic progress notes indicated that a visitor reported immediately that the resident left the building and was heading down a specified location. The documentation from the resident's electronic progress notes indicated that the home's video surveillance revealed that at a specified time, resident #001 was trying to exit a home area exit door; two minutes later, the resident was seen at the adjacent home area towards the main entrance; five minutes later, the resident had successfully entered the door code at the main entrance while a visitor was coming in to the home and alerted the home staff. Eight minutes later, the resident was brought back to the home by a staff member.

Inspector #687 further reviewed resident #001's electronic progress notes which indicated that the resident had specified behaviour 9 times over a 37 day period.

In a review of resident #001's current electronic care plan, Inspector #687 did not identify any focus and interventions for the resident's specified behaviour.

In a review of the home's policy titled "Resident Assessment Instrument RAI-MDS Policy + Care Planning" last reviewed on October 23, 2018, which indicated that the registered staff and skilled staff were to consistently and accurately gather information regarding resident needs and strengths which provides the foundation for an individualized interdisciplinary plan of care. It also indicated that when a significant change in the

resident's status was identified by appropriate Registered Nurse/ Registered Practical Nurse (RN/RPN), a care plan review and revision would be made.

During an interview with Personal Support Worker (PSW) #107, they stated that resident #001 had specified behaviours.

In an interview conducted by Inspector #687 with RN #105, they stated that resident #001 had specified behaviours. The RN further stated that the resident's care plan was not updated to reflect their significant behavioural change.

During an interview with the Director of Care (DOC), they stated that resident #001 had no specified behaviour prior to the specified date of the incident. The DOC acknowledged that the resident's care plan should have been updated when the resident was identified with the specified behaviour under the focus for safety.

b) The home submitted a Critical Incident (CI) report to the Director, which indicated an alleged improper care of resident #002 for not being provided a meal on a specified date.

Inspector #687 observed resident #002 in a home area dining room on specified dates and they were observed being assisted by staff members with their meal.

In a review of resident #002's electronic care plan in effect at the time of the incident indicated that when the resident had specified behaviours, the staff were to set-up the resident's meal in a specified location outside the dining room. When the resident requested to have their meal in the dining room and had no specified behaviours, the staff were to attempt to set-up the resident's meal in the dining room.

During an interview with PSW #104, they stated that resident #002 required total assistance with their meal service in the dining room.

In an interview conducted by Inspector #687 with RPN #103, they stated that they were working on the specified date and that a PSW had forgotten to provide resident #002's meal. The RPN further stated that the resident was to have their meal at the specified area to decrease their risk of behaviours.

During an interview with the DOC, they stated that the staff were to provide meal service to resident #002 at a specified area to decrease their risks of behaviours. The DOC further stated that on a specified date, a PSW had forgotten to provide a meal to the

resident. The DOC acknowledged that the resident's care plan did not indicate that the resident was to have their meals in the specified area. The DOC further stated that the care plan should have been updated at that time to reflect the change. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary,, to be implemented voluntarily.

Issued on this 30th day of July, 2019

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

Original report signed by the inspector.