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
Oct 2, 2019	2019_680687_0027	018022-19	Complaint

Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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 Complaint inspection.

This inspection was conducted on the following date(s): September 23 to 27, 2019.

This Complaint Inspection was related to a complaint received by the Director regarding insufficient Administrator/Director of Care (DOC) hours.

In addition, a Follow Up Inspection #2019_680687_0026 was conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator and staff members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to the residents, observed staff to resident interactions and reviewed relevant records.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

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	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 O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.

A complaint was submitted to the Director, which indicated insufficient Administrator work hours in the home which affects resident care and management consistency. The complainant further indicated that the Administrator was supposed to be on-site for a specified number of days a week but would only be present in the home for few hours.

A review of the Administrator's work hours was reviewed by Inspector #687 and it was identified that there were two specified dates that did not amount to the 24 hours required in the home.

In an interview with staff member #114, they stated that they saw the Administrator in the home at least a number of days a month and stated that the Administrator should be in the home more often to oversee things.

Inspector #687 interviewed staff member #119 who stated that the Administrator would come in the home, part of the day, a number of days a week.

In an interview conducted by Inspector #678 with staff member #120, the staff member stated that they saw the Administrator in the home a number of days a week.

Inspector #687 interviewed staff member #101, they stated that they saw the Administrator a number of days a week. The staff member further stated that the Administrator would greet the staff and the residents when they were on-site.

In an interview with staff member #118, they stated that they saw the Administrator a number of days a week as the Administrator would walk down the nursing station to conduct their supervision.

The Inspector interviewed staff member #112, they stated that they saw the Administrator a number of days a week. The staff member further stated that there were days when the Administrator would leave the home to attend off-site meetings.

Inspector #678 interviewed staff member #104 and stated that the Administrator would come in part of the day and they verified that the Administrator was not in the home as mandated.

In an interview conducted by Inspector #687 with the Administrator, they stated that they were the CEO for three hospitals as well as the Administrator for three long-term care homes. The Administrator further stated their work hours changes all the time but kept their hours in their calendar. The Administrator informed Inspector #687 that they work a specified number of days for the three homes. The Administrator acknowledged that it was difficult to keep track of their work hours and was uncertain if they were keeping their 24 hours work schedule for the home. [s. 212. (1)]

Issued on this 3rd day of October, 2019

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

Original report signed by the inspector.