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 25, 2019	2019_640601_0012	027279-18, 028287-18, 030405-18, 032713-18, 003403-19	Complaint

Licensee/Titulaire de permis

Centennial Place Millbrook Inc.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

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

Centennial Place Long-Term Care Home
2 Centennial Lane North MILLBROOK ON M5J 2G2

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

KARYN WOOD (601)

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): May 16, 17, 22, 23, 24, 28, 29, 30, 31, June 4, 5, 6, 10, and 11, 2019.

Complaint logs #030405-18, log #032713-18 and log #003403-19 related to application to the Long-Term Care Home was withheld.

Complaint log #027279-18 related to a decline in the resident's health status, care concerns and staffing.

Complaint log #028287-18 related to insufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care (ADOC), the Director of Dietary Service, the Dietitian, Behaviour Support Coordinator (BSC), RAI-Coordinator (RAI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Placement Coordinators of the Central East (CE) Local Health Integration Network (LHIN) and Hospital, a family member and residents.

The inspector also reviewed residents' health care records, the licensee's relevant policies and procedures, staffing schedules and observed the delivery of resident care and services, including resident to staff interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

2 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 LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when withholding approval for admission, the licensee shall give a written notice setting out an explanation of how the supporting facts justify the decision to withhold approval for applicants #006 and #008.

Related to complaint log #030405-18:

A written complaint was received by the Director on a specified date from the Placement Coordinator of the Central East (CE) Local Health Integration Network (LHIN), regarding applicant #006. Inspector #601 reviewed the written complaint, which indicated that applicant #006 had applied for admission to the home and had been denied by the Long-Term Care Home (LTCH) on a specified date. According to the written complaint, the applicant was residing on a specialized unit and had an identified diagnosis.

During a telephone interview on a specified date, the complainant indicated to Inspector #601 that applicant #006 was transferred to an identified facility and was not displaying the identified responsive behaviour at the time of the application to the LTCH.

Inspector #601 reviewed the licensee's letter addressed to applicant #006 and signed by the Administrator of the LTCH on a specified date. The letter stated the following details for withholding approval for applicant #006's admission to the LTCH:

An updated application for Long-Term Care (LTC) placement was received and it revealed a number of behavioural concerns which would preclude admission to the home. These behaviour expressions pose a significant risk to both applicant #006 and those around them. The home lacks the staffing levels and physical facilities needed to manage the specified behaviour in an open environment where residents with these behaviours are mixed in with other vulnerable residents. Specifically, the size and nature of the physical layout of the resident home areas and the vulnerability of the frail and mobile residents would make it difficult to provide a safe environment both for the applicant and the vulnerable resident population.

During an interview on a specified date, the Administrator indicated to Inspector #601, that at the time the letter was written by the Administrator on the specified date, the Long-Term Care Home (LTCH) did not have the staff to provide the identified monitoring to manage the applicant's behaviours. The Administrator further indicated the LTCH did not have the physical facility which included to monitor applicant #006 all the time. According to the Administrator, the multidisciplinary team, including the Behaviour Support Coordinator reviewed the application and determined it would not be safe to accept applicant #006's application to the LTCH at the time of the application.

A further review of the refusal letter with a specified date, revealed that the refusal letter did not provide a detailed explanation of the supporting facts, or how the facts justify the decision to withhold approval regarding applicant #006's application to the LTCH.

The licensee failed to ensure that the letter addressed to applicant #006 provided sufficient details as required, for withholding approval for admission, and an explanation of how the supporting facts justified the decision to withhold approval.

Related to complaint log #032713-18:

A written complaint was received by the Director on a specified date from the Placement Coordinator of the Central East (CE) Local Health Integration Network (LHIN), regarding applicant #008. Inspector #601 reviewed the written complaint, which indicated that applicant #008 had applied for admission to the home and had been denied by the LTCH on a specified date. According to the written complaint letter, the LTCH did not provide detailed explanation of supporting facts of the reason the home could not manage applicant #008, as the applicant had no behaviour concerns identified since a specified date.

During an interview on a specified date, the complainant indicated to Inspector #601 that applicant #008 had been transferred to a specified facility with identified responsive behaviours. According to the complainant, applicant #008's behavioural assessment at the time of the application to the LTCH indicated that applicant #008's responsive behaviours were now manageable.

Inspector #601 reviewed the licensee's letter with a specified date, addressed to applicant #008, and signed by the Director of Care (DOC) of the Long-Term Care Home (LTCH). The letter stated the following details for withholding approval for applicant #008's admission to the LTCH:

The home received an updated application for LTC placement and it revealed a number of behavioural concerns which would preclude admission to the home. These behaviour expressions pose a significant risk to both applicant #008 and those around them. The home lacks the staffing levels and physical facilities needed to manage identified behaviour in an open environment where residents with these behaviours are mixed in with other vulnerable residents. Specifically, the size and nature of the physical layout of the home areas and the vulnerability of the frail and mobile residents would make it difficult to provide a safe environment both for the applicant and for the vulnerable resident population.

During a telephone interview on a specified date, the Director of Care (DOC) indicated to Inspector #601 that at the time the letter was written by the DOC on the specified date, the application indicated the applicant required a specified accommodation and the applicant had not applied for this type of room. Applicant #008 had a history of identified behaviours. According to the DOC, it would have been difficult to manage applicant 008's responsive behaviours at the time of the application to the LTCH

A further review of the refusal letter with a specified date, revealed that the refusal letter did not provide a detailed explanation of the supporting facts or how the facts justify the decision to withhold approval regarding applicant #008's application to the LTCH.

The licensee failed to ensure that the letter with a specified date, addressed to applicant #008 provided sufficient details as required, for withholding approval for admission, and an explanation of how the supporting facts justified the decision to withhold approval. [s. 44. (9)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was offered a minimum of three meals daily.

Related to complaint log #027279-18:

A complaint was received by the Director on a specified date from resident #009's Substitute Decision Maker (SDM) regarding care concerns.

During separate interviews on a specified date, resident #009 and their SDM indicated to Inspector #601 that resident #009 chose not to attend meals in the dining room for a specified reason. Resident #009 and their SDM also indicated that it was their understanding that resident #009 could only have food and fluid items provided from the nourishment cart if the resident decided to remain in their bedroom during meal services. They both indicated they had been informed by staff that the resident could only receive meal tray services if they were not feeling well. Resident #009 further indicated they had recently spoken with the Dietitian, who had informed them that tray service could be provided to their bedroom if the resident decided to not attend the dining room. Resident #009 indicated they were now receiving tray service of a specified food item for two specified meals and a specified food was being provided for the third meal from the nourishment cart, as a substitution for the specified meal.

Record review of resident #009's progress notes documented by the Dietitian on a specified date and time, indicated that resident #009 was receiving specified food items for two identified meals, was to be provided with a specified food from the nourishment cart, for the resident to snack on should they chose to remain in their bedroom during the specified meal and the written plan of care would be updated to indicate the same.

During an interview, PSW #134 indicated to Inspector #601 that staff would ask resident

#009 if they wanted to attend the dining room for meal service but would not offer a meal or tray service if the resident remained in their bedroom during the meal. PSW #134 further indicated that resident #009 would later be offered a snack from the nourishment cart, which offered a choice of a specified food, depending on the day, if they remained in their room during the meal service.

During an interview, RPN #129 indicated to Inspector #601 that resident #009 had spoken with the Dietitian and was now being offered specified food and fluid items in their bedroom for two specified meals but would not be offered tray service during the specified meal.

During an interview, the Dietitian indicated to Inspector #601 that they had spoken to resident #009 about their meal preferences and the resident had informed them that they preferred to remain in their bedroom during meal services. According to the Dietitian, resident #009 had requested the specified items for the two specified meals and a specified food from the nourishment cart for the specified meal and they had updated resident #009's written plan of care to indicate the resident's preferences. The Dietitian further indicated the expectation in the home was that tray service was to be offered to all residents who chose to remain in their bedrooms during meal services and the PSWs should offer each available meal option to each resident who did not attend the dining room, as per a specified internal policy.

Inspector #601 reviewed the specified internal policy which indicated the expectation in the home was that residents were to be served meals in the dining room except during specified occasional circumstances which may require monitored tray service in a resident's bedroom. The internal policy further indicated that tray service was to be provided after the meal service in the dining room was finished, regular use of the tray service was expected to be identified individually and documented in the resident's plan of care, and an evaluation of the need for the tray service was to be completed and the Director of Dietary Services was to be updated daily until the resident could return to the dining room. Staff were expected to offer the posted menu items and use show plates for all residents who received a diet other than clear or full fluids, and then request tray services from the Dietary Aide (DA) in the server. The RN/RPN was also expected to discuss all options and alternatives with the resident, SDMs and other inter-professional team members and then document the outcomes in the resident's progress notes.

During an interview, the Director of Dietary Services and the Director of Care indicated to Inspector #601 that they were not aware that staff had been telling resident #009 they

were to eat their meals in the dining room and both indicated that resident #009 should have been provided a meal when they chose to remain in their bedroom during meal service.

The licensee did not ensure that resident #009 was offered a minimum of three meals daily. [s. 71. (3) (a)]

Issued on this 20th day of August, 2019

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

Original report signed by the inspector.