



**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 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
Direction de l'amélioration de la
performance et de la conformité**

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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
Mar 8, 2013	2013_139163_0006	1376-12, 1378-12	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): March 5th and 6th, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, registered nurses (RNs), registered practical nurses (RPNs), housekeeping staff, personal support workers (PSWs), and residents.

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

**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.)

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Inspector reviewed the documentation of a Critical Incident involving resident #1378 who had a medical history that included osteoporosis. The Critical Incident notes and the resident's health care record indicate that registered staff became aware that this resident was experiencing pain in their leg and was subsequently sent to the hospital for assessment. Supervisory staff #101 reported to the inspector that direct care staff were interviewed about the care provided to the resident prior to the onset of pain. Staff #101 added that staff #201 who provided direct care to the resident prior to the onset of the resident's pain, reported to use a sit to stand lift often in the transfer and care of resident #1378. The inspector reviewed the plan of care for resident #1378. The plan of care required a full mechanical lift with two staff present, for the transfer and care of resident #1378.

The licensee has not ensured that the care set out in the plan of care is provided to resident #1378 as specified in their plan. [s. 6. (7)]



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 those residents whose care includes the use a full mechanical lift for transferring, that their care, as set out in their plan of care, is provided as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The inspector reviewed a Critical Incident involving resident abuse. The inspector also reviewed staff training and education records of the home on the prevention of abuse and neglect, and the home's policy to promote zero tolerance of abuse and neglect of residents. In the home's policy it states that annually, all employees will receive education and training on the home's abuse policy as well as identification, prevention and reporting requirements. The policy adds that staff are to immediately report any suspected or witnessed abuse to a supervisor or department head. The Critical Incident documents along with statements provided by staff #101 indicate that a staff member was aware of the alleged incident of abuse of a resident, however did not immediately report the incident to a supervisor or department head until several days later.

Upon review of the training records with supervisory staff #101 it was noted by the inspector that in 2011 and 2012 not all employees received training on the home's policy to promote zero tolerance of abuse and neglect of residents. Inspector found that in the year 2012, 12 of the approximately 70 employees in the home received training on the home's policy to promote zero tolerance of abuse and neglect of residents. Staff #101 added that a similar number of staff (12) attended in 2011. The licensee has not ensured that the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with. [s. 20. (1)]



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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 licensee complies with the home's policy for promoting zero tolerance of abuse and neglect of residents, particularly with regards to annual training of the policy for all employees and reporting requirements for suspected or witnessed incidences of resident abuse or neglect, to be implemented voluntarily.

Issued on this 8th day of March, 2013

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

Diana Fenlund, #163