Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'Inspection
Nov 21, 22, 26, Dec 4, 2012	2012_140158_0027	Other

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and families.

During the course of the inspection, the inspector(s) reviewed residents' health care records and observed care provided to residents.

The following inspection Protocols were used during this inspection:

Dining Observation

Residents' Council

Findings of Non-Compliance were found during this Inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 compiy with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to compiy with the following subsections:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that resident # 04 was reassessed and that the plan of care was reviewed and revised when the resident's care needs changed.
Resident # 04 has a medical condition that puts their body's electrolyte balance at risk. As per the resident's physician record, a change to resident # 04 electrolyte balance started in August 2012 and in September 2012, the physician ordered a diet to manage the resident's intake of potassium, sodium and fluid. This diet change was not documented in the resident's written plan of care. Although a 2010 nutritional assessment was completed by the dietitian, there were no recent assessments found completed. Staff # 103 identified on November 21, 2012 that the dietitian has not re-assessed the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (10) (b)]
2. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and complement each other.
Resident # 04 has a medical condition that puts their body's electrolyte balance at risk. As per the resident's physician record, a change to resident # 04 electrolyte balance started in August 2012 and in September 2012, the physician ordered a diet to manage the resident's intake of potassium, sodium and fluid intake. On November 21, 2012 at 12:10hr, the Inspector observed that when the meal (potatoes/gravy, corn and chicken) was plated by staff # S-100 for resident # 04, staff # S-102 who was serving the resident, questioned the meal. This diet change was not documented in the resident's written plan of care. This diet change was not documented on the diet list, however, staff # S-100 pointed to a printed guideline which was taped to the wall. This guideline identified food which were low and high in potassium. Staff S-100 stated that it was difficult to determine what to give resident # 04 to eat as clear direction was not provided.
[LTCHA 2007, S.O. 2007, c. 8, s. 6 (4) (b)]
3. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and complement each other.
On November 21, 2012, resident # 03 was observed by the Inspector to choke and spit out the soup which was given to them at lunch. It was documented on the diet list that resident # 03 is to receive a puree – minced regular diet. It was documented in the resident's plan of care that the resident is to receive a puree diet. An assessment by Staff # S-101 in November 2012 identified that a minced diet with regular fluids is to be implemented, however, the resident received a regular textured soup and puree meal at lunch. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (4) (b)]
4. On November 21, 2012, resident # 03 was observed by the Inspector to choke and spit out the soup which was given to them at lunch. The Inspector observed that the regular texture soup given to them was then replaced with a puree soup. Staff # S-100 provided the Inspector with the resident diet list. It was documented on the diet list that resident # 03 is to receive a puree – minced regular diet. It was documented in the resident's plan of care that the resident is to receive a puree diet. In November 2012, the dietitian assessed resident # 03 as requiring a minced diet. The licensee did not ensure that the care set out in the plan of care was provided to resident # 03 as specified in the plan. [LTCHA 2007, S.O. 2007, c.8 s. 6 (7)]
5. On November 21, 2012, the Inspector observed at 09:10hr and at 12:00hr that resident # 02 hair was not combed and their finger nails and hands were soiled. The resident's plan of care which was reviewed by the Inspector on November 21, 2012 identified that the resident requires total assist and verbal cueing of 1 staff to comb their hair and wash/dry their face. The licensee did not ensure that the care set out in the plan of care was provided to resident # 02 as specified in the plan. [LTCHA 2007, S.O. 2007, c.8 s. 6 (7)]
6. On November 21, 2012, the Inspector observed that resident # 01 had remnants of toast and jam (food debris) on their face at 12:00hr. The resident's hair was not combed and their finger nails and hands were soiled. The resident's plan of care which was reviewed by the Inspector on November 21, 2012 identified that the resident requires total care/assistance of 1 staff to comb their hair and wash/dry their face. The care as set out in the plan of care was not provided to resident # 01. [LTCHA 2007, S.O. 2007, c.8 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 ensuring that the care as set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following subsections:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. Resident # 04 has a medical condition that puts their body's electolyte balance at risk. As per the resident's physician record, a change to resident # 04 electrolyte balance started in August 2012 and in September 2012, the physician ordered a diet to manage the resident's intake of potassium, sodium and fluid. The health care record for resident # 04 was reviewed by the Inspector and showed that a nutritional assessment by the dietitian was completed in 2010, however, there has been no further assessments completed by the dietitian. Staff # S-104 identified on November 21, 2012 that they do not have a dietitian who is regularly on site at the home. Staff # S-105 identified on November 21, 2012 that the dietitian does not complete the dietitian's legislated 39 hours a month requirement. The licensee did not ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. [O. Reg. 79/10, s. 74 (2)].

Issued on this 4th day of December, 2012

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