Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
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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
Jun 4, 2014	2014_339579_0007	S-000081-14	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

JANET MCNABB (579)

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): May 27 and 28, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Registered Staff, Personal Support Workers, Residents and the Educator who is also the Director of Care.

During the course of the inspection, the inspector(s) walked through the home, observed resident care, reviewed policies, reviewed health care records and education resources provided to all staff.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Inspector reviewed Critical Incident System (CIS)report #C598-000002-14 that occurred in 2014, involving resident #001 that resulted in a fall by resident #001 and subsequently suffered with injuries of multiple skin tears. Inspector reviewed resident #001's care plan corresponding to the care required prior to the incident. The care plan outlined that 2 staff are required to assist resident #001 with transfers.
There was documentation in the progress notes as well as in the CIS report, that resident #001 did get transferred by staff #101 as a one person assist when the care plan and documentation supported and indicated that resident was to be a two person assisted transfer.

2. On May 27, 2014 inspector reviewed the personnel records for staff #101 noting they had several prior disciplinary actions filed against them relating to resident abuse and/or neglect.

The licensee failed to ensure that residents are protected from abuse by anyone and failed to ensure that residents are not neglected by the licensee or staff. [s. 19. (1)]

Issued on this 4th day of June, 2014

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