Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 6, 7, 8, 2011	2011-173-2948-06Apr082542	Complaint Log #H00120 Complaint Log #H00216

Licensee/Titulaire
9555464 Ontario Limited
3700 Billings Court, Burlington, Ontario L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée
Millennium Trail Manor
6861 Oakwood Drive, Niagara Falls, Ontario L2E 6S5

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – LTC Homes Inspector – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two complaint inspections.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care (DOC), RAI Coordinator, Registered Staff, Personal Support Workers, Residents, and Families.

During the course of the inspection, the inspector: Reviewed clinical health records, reviewed policy and procedure, observed residents, conducted interviews.

The following Inspection Protocols were used in part or in whole during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Responsive Behaviours Inspection Protocol
Dignity, Choice and Privacy Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN
7 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.3(1)1
Every Licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(1) Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. The management of the home did treat an identified resident with respect and dignity in relation to a personal choice voiced to the team. It was confirmed by the resident that the resident did not feel treated with courtesy and respect and dignity during the interactions with the management team.

Inspector ID #:	173

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 related to ensuring that all residents are treated with courtesy and respect at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.3(1)14
Every Licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(14) Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

Findings:

1. An identified resident's rights were not respected and promoted during communication with a family member. Details of this private conversation were shared with the management team by staff.

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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 related to ensuring that all residents are able to communicate in private without interference, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.8(1)(b)
Where the Act or this Regulation requires the licensee of a long-term care home to have, institute, otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is
(b) complied with

Findings:

1. The home did not follow policy and procedure for an identified resident related to assessment post fall, initiating and completing head injury routine as per policy and procedure.

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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 related to ensuring all plans, policies, protocols, procedures, strategies or systems are to be complied with, to be implemented voluntarily.

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WN #4: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(1)(c)
Every licensee of a long term care home shall ensure that there is a written plan of care for each resident that sets out
(c) Clear directions to staff and others who provide direct care to the resident.

Findings:

1. An identified resident with aggressive behaviours resulting in several altercations with other residents causing injury did not have a written plan of care in place that provided staff with clear direction to prevent or mitigate these behaviours.

Inspector ID #:	173

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 related to ensuring that the written plan of care sets out clear direction to staff who provide direct care to the resident to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10 s.26(3)5
A plan of care must be based on at a minimum, interdisciplinary assessment of the following with respect to the resident:
(5) Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Findings:

1. The plan of care for an identified resident presenting with aggressive behaviours was not based on an interdisciplinary assessment that included mood and behaviour patterns, potential triggers and/or variations in resident function at different times of the day.

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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 related to ensuring that the plan of care includes Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10 s.53(4)(c)
The licensee shall ensure that, for each resident demonstrating responsive behaviours
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions are documented.

Findings:

1. Actions were not taken by the home in response to aggressive behaviours of an identified resident that included assessments, reassessments, interventions and response to interventions. During this time, several altercations took place between the identified resident and co-residents that resulted in injury.

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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 related to ensuring actions are taken to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.

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WN #7: The Licensee has failed to comply with O.Reg 79/10 s.54(b)
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including
(b) identifying and implementing interventions.

Findings:

1. Episodes of verbal and physical aggression from an indentitfied resident began on admission and escalated to include several altercations between residents that resulted in injury. The home did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents. Staff documented the incidents but did not communicate these altercations until injury had occurred.

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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 related to ensuring that the home takes steps to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lesa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). July 19/11