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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 4, 2016	2016_248214_0012	018372-16	Complaint

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MILLENNIUM TRAIL MANOR
6861 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

CATHY FEDIASH (214)

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): June 22 and 23, 2016.

Please note: The following inspections were conducted simultaneously with this Complaint Inspection:

-Critical Incident System 018044-16 related to Responsive Behaviours
-Critical Incident System 018335-16 related to Responsive Behaviours
-Critical Incident System 018328-16 related to Discharge

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Behavioural Supports Ontario (BSO), Nurse Practitioner (NP), Personal Support Workers (PSW) and a resident. During the course of this inspection, the inspector toured the first floor unit, reviewed Critical Incident Systems, reviewed resident health records, reviewed a letter of discharge and observed residents in care areas.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of a Critical Incident System (CIS) indicated that on an identified date in 2016, resident #100 was witnessed to have demonstrated physically responsive behaviours toward a co-resident which resulted in the co-resident sustaining an injury.

A review of the resident's clinical record for an identified period of time in 2016 indicated that the resident demonstrated known responsive behaviours that included verbal and physical behaviours towards co-residents and staff and sexually responsive behaviours towards staff.

A) On an identified date in 2016, the resident demonstrated sexually inappropriate behaviours towards staff. Documentation indicated the resident was redirected and reminded that their actions were inappropriate; however, no documentation of the resident's response to these actions was noted.

B) On the day following the example above, the resident continued to demonstrate sexually inappropriate behaviours. The resident was reminded that their behavior was inappropriate; however, no documentation was included as to the resident's response when informed that their actions were inappropriate.

C) Four days following the example above, the resident demonstrated verbal and physical responsive behaviours and was noted to be yelling threats to a co-resident. Documentation indicated that the resident continued to demonstrate physically responsive behaviours towards co-residents and staff. Documentation indicated that the resident was not easily redirected. No documentation was included as to the resident's response when attempts to redirect were made.

D) Two days following the example above, documentation indicated that the resident was very aggressive demonstrating physically responsive behaviours towards co-resident's. Documentation indicated that the resident was difficult to redirect and was verbally aggressive toward staff yelling profanities. No documentation was included as to what actions were taken when the resident was physically responsive toward co-resident's and yelled profanities toward staff and no documentation was included as to the resident's response to actions that where taken.

E) Three days following the example above, documentation indicated that the resident was verbally aggressive toward co-residents. The resident also demonstrated physically responsive behaviours towards staff and co-residents. No documentation had been included as to what actions were taken and the resident's response to any actions.

F) The day following the example above, during the early morning hours, documentation indicated that the resident was wandering throughout the unit and going into other residents' rooms and was demonstrating verbally responsive behaviours towards staff. No documentation was included as to what actions were taken including the resident's response to any actions taken.

G) On the same day as the example above, during the evening hours, documentation indicated that the resident was verbally aggressive toward co-residents. Documentation indicated that the resident continued to be physically aggressive toward co-residents and staff. No documentation was included as to what actions were taken including the resident's response to any actions taken.

H) The day following the example above, documentation indicated that the resident demonstrated four episodes of verbal aggression that were easily redirected; however, no documentation had been included as to what actions the staff had taken that resulted in the resident's behaviours being easily redirected or the resident's response to the action(s) taken.

I) The day following the example above, documentation indicated that the resident attempted to strike out at a staff member and was easily redirected; however, the documentation had not identified what actions staff had taken that resulted in the resident's behaviours being easily redirected or the resident's response to the action(s) taken.

J) Two days following the example above, documentation indicated that the resident was becoming verbally aggressive and used profanity toward staff. No documentation had been included as to what actions were taken or the resident's response to any action taken.

K) Eleven days following the example above, documentation indicated that the resident was physically aggressive toward a co-resident. Documentation indicated that no injuries were sustained and that the behaviour was easily altered; however, had not indicated what actions were taken or the resident's response to the action(s) taken.

L) The day following the example above, documentation indicated that the resident was physically and verbally aggressive toward co-residents. Documentation also indicated that the resident was verbally and physically responsive toward staff. Documentation indicated that the behaviour had not been easily altered; however, had not identified what actions had been taken or the resident's response to the action(s) taken.

M) Seven days following the example above, documentation indicated that the resident demonstrated verbally and physically responsive behaviours toward a co-resident. No documentation was included as to what actions were taken or the resident's response to any action(s) taken.

N) Two days following the example above, documentation indicated that the resident demonstrated physically responsive behaviours towards a staff member while they were providing care to another resident. Documentation indicated that no injuries were sustained and that resident #100 was removed from the area; however, had not indicated what the resident's response was to this action.

O) Two days following the example above, documentation indicated that the resident demonstrated physically responsive behaviours towards a co-resident. Documentation indicated that no injuries were sustained; however, had not included what actions were taken or the response of the resident to any action(s) taken.

P) Three days following the example above, documentation indicated that resident #100 was the recipient of physical aggression by a co-resident. Documentation indicated that resident #100 in turn demonstrated physically responsive behaviours towards this co-resident. It was indicated that that both residents were redirected; however, no documentation was included as to the resident's response when this action took place.

An interview with the DOC confirmed that for the incidents noted above, documentation had not been completed regarding actions taken to respond to the needs of resident #100 or the resident's response to any interventions that were implemented when the resident demonstrated responsive behaviours.

(PLEASE NOTE: The above noted non-compliance was identified while conducting concurrent Critical Incident System's Log # 018044-16 and #018335-16). [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
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,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A review of a Critical Incident System (CIS) indicated that on an identified date in 2016,

resident #200 had demonstrated physically responsive behaviours towards resident #100, causing a reddened area to an identified area on their body. The CIS indicated that both residents were separated immediately.

A review of the resident's progress notes for an identified period of time in 2016, indicated that resident #200 had verbal and physical altercations without injury toward other co-resident's on four identified dates in 2016.

A review of resident #200's quarterly Minimum Data Set (MDS) dated on an identified date in 2016, indicated under section E. Mood and Behaviour Patterns, that the resident was coded as demonstrating verbal and physical behaviours that had occurred four to six days, but less than daily during the seven day review period. A review of the corresponding narrative Resident Assessment Protocol (RAP) dated the same day, indicated that the resident could be verbally and physically aggressive and that the behavioural symptoms would be addressed in the care plan.

A review of a progress note titled, Annual Charting and dated with an identified date in 2016, indicated that the resident did have altercations with co-residents and would demonstrate verbal and physical responsive behaviours. No interventions were identified in this assessment to minimize the risk of altercations and potentially harmful interactions between resident #200 and other co-residents.

A review of the resident's written plan of care dated with an identified date in 2016, identified a behavioural problem focus that included verbal and physical responsive behaviours; however, interventions identified were for the management of these behaviours toward staff only and had not included interventions to minimize the risk of altercations between residents.

An interview with the Administrator and the DOC confirmed that the home had not identified and implemented interventions to minimize the risk of altercations between resident #200 and co-residents.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent Critical Incident System Log # 018044-16). [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214)
Inspection No. / No de l'inspection :	2016_248214_0012
Log No. / Registre no:	018372-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 4, 2016
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MILLENNIUM TRAIL MANOR 6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee is to ensure that for each resident demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The home shall provide education on documentation requirements for each resident demonstrating responsive behaviours and the requirement to ensure that the resident's responses to interventions are documented. This education shall be provided to all staff who are responsible for documenting resident's behaviours.

The licensee shall conduct auditing activities of resident's clinical records at a frequency and schedule as they determine to ensure that actions are taken to respond to the needs of resident's and that the resident's responses to interventions are documented for each resident demonstrating responsive behaviours.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the risk of actual harm to resident #200, the scope of "widespread" within the context of a Critical Incident System Inspection and the

licensee's history of ongoing non-compliance (VPC) May 22, 2016, Complaint Inspection related to r.53(4)(c).

The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of a Critical Incident System (CIS) indicated that on an identified date in 2016, resident #100 was witnessed to have demonstrated physically responsive behaviours toward a co-resident which resulted in the co-resident sustaining an injury.

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A) On an identified date in 2016, the resident demonstrated sexually inappropriate behaviours towards staff. Documentation indicated the resident was redirected and reminded that their actions were inappropriate; however, no documentation of the resident's response to these actions was noted.

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documentation was included as to what actions were taken when the resident was physically responsive toward co-resident's and yelled profanities toward staff and no documentation was included as to the resident's response to actions that where taken.

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An interview with the DOC confirmed that for the incidents noted above, documentation had not been completed regarding actions taken to respond to the needs of resident #100 or the resident's response to any interventions that were implemented when the resident demonstrated responsive behaviours.

(PLEASE NOTE: The above noted non-compliance was identified while conducting concurrent Critical Incident System's Log # 018044-16 and #018335-16).

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

Service Area Office /
Bureau régional de services : Hamilton Service Area Office