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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2019_734674_0002	032627-18	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

JOSEE SNELGROVE (674)

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): January 30, 31, February 1, 4, and 5, 2019.

During the course of the inspection, the inspector(s) reviewed resident clinical records; and the home's internal investigative notes.

Kelly Chuckry, Inspector # 611 was present during the complaint inspection.

Two (2) Critical Incident Report (CIS) inspections and one (1) Follow up inspection were conducted concurrently with this inspection. These included:

- CIS Log # 032584-18 pertaining to Medication Management and Log # 033527-18 pertaining to Prevention of Abuse and Neglect and Plan of Care.

- Follow Up Log # 003812-18 pertaining to Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered staff, Personal Support Workers (PSWs), and the complainant.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The Licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A review of a complaint inspection log # 032627-18, identified concerns related to skin and wound management, equipment and notification of substitute decision maker (SDM) in decisions when the resident care needs had changed.

According to progress notes, resident # 002 had an alteration in skin integrity noted on a specified date. On this date the physician was notified and a new treatment was prescribed.

According to the Physician's Order form on a specified date, there is no indication that the resident, power of attorney (POA), or family were notified of the new treatment changes. Specifically the form includes a tick box to identify that the SDM was notified, it was not checked off to indicate that the SDM was informed.

Further review of the clinical health record, a progress note from a specified date indicated that there is no documentation to support that the SDM was notified of the treatment changes. Another entry on an alternate date, included a statement where the home's physician identified that they should have been called with the additional treatment and offered apologizes on their behalf.

In an interview with the Administrator, on a specified date, it was confirmed that the SDM was not notified when a new treatment was initiated for resident # 002. It was further confirmed that it is the expectation of the registered staff to notify the SDM when such changes are made for the resident. The SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care for resident # 002.

Issued on this 8th day of February, 2019

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

Original report signed by the inspector.