Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 15, 2019	2019_558123_0007	001964-19	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

MELODY GRAY (123)

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): May 8, 9, 24, 28, 29, 30, 31, June 6, 11, 13 & 14, 17, 18, 19, July 23, 31 and August 2, 2019.

During the course of the inspection, the inspector: reviewed residents' health records; reviewed the home's records including polices and procedures and observed residents, equipment and staff-resident interactions.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), registered staff, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Assistant Director of Care (ADOC), the Director of Care (DOC), the Nurse Practitioner (NP) and the Administrator.

The following complaint inspection was included in this inspection: #001964-19 related to plan of care.

The following Critical Incident (CI) inspection was conducted concurrently with this inspection: 2019_558123_0008 / 007789-19, 008092-19, 009096-19, 009178-19, 009868-19.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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 :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Long-Term Care (MOLTC) received a complaint from a family member of resident #001 on an identified date in January 2019, identifying concerns related to not being included in the development of resident #001's plan of care.

The health record of resident #001 including; physician's orders, January 2019, Medication Administration Record (MAR), progress notes and hospital Discharge Summary was reviewed. Progress note documentation indicated that at an identified time on an identified date in January 2019, resident #001 was assessed as experiencing identified symptoms.
The resident had an identified symptom and they also reported an additional symptom. The resident was assessed and treated with identified medications. A sample of the resident's identified bodily fluid was collected for identified diagnostic testing that day. The resident continued to have identified symptoms and medications were administered to treat the symptoms.

The resident's Physician's Order Form indicated that on the identified date in January 2019, at an identified time three medications were ordered to be administered.
The resident's January 2019, MAR indicated that on the identified date in January 2019, the staff administered the two identified medications to the resident.

Registered staff #110, reported information as documented in the progress notes including: They assessed the resident earlier that day and there was a change in the resident's health status.

The Director of Care (DOC) reported information as noted in the progress notes. They also indicated the NP treated the resident and directed the staff to send the resident out. The registered staff administered the treatment. The SDM was not aware that the resident was being treated.

The NP was interviewed and reported information as noted in the progress notes. They also indicated they obtained the resident's consent and phoned the family member as documented in the progress notes.

The resident was interviewed and reported they wanted their SDM to be informed when they were not feeling well and about their medications.

On the identified date in January 2019, the home did not ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care when the resident's health status changed, medications were administered to the resident, an identified body fluid sample was collected from the resident and the staff waited to see whether the resident's condition would improve.

This area of non-compliance was issued as a result of complaint inspection #001964-19. [s. 6. (5)]

2. Incident Critical (CI) report #2948-000003-19/#004534-19 submitted to the Ministry of Long-Term Care (MOLTC) on an identified date in February 2019 and CI report #2948-000008-19/#009096-19 submitted to the MOLTC on an identified date in May 2019, were reviewed. Both CI reports were in relation to alleged resident-to-resident abuse involving resident #012.

A. The health record including; the progress notes, care plan, kardex and the Medication Administration Record (MAR) of resident #012, who had a history of behaviours towards staff and co-residents was reviewed.
Progress notes documentation indicated the resident was involved in multiple incidents of physical responsive behaviours with residents and staff from February to May 2019. It was noted that at times when the resident displayed responsive behaviours, additional staff response was required to ensure activities of daily living were completed.
The DOC confirmed the additional staff were needed at times to assist the resident with activities of daily living due to the resident's responsive behaviours.

The resident's Substitute Decision-Maker (SDM) was interviewed and they confirmed they have not been provided an opportunity to participate in care decisions for resident #012, regarding activities of daily living. They denied having had discussions with the home about the strategies that would be implemented in specific situations.
The review of the resident's health record indicate that the resident's SDM was notified after some incidents of responsive behaviours.

B. The health record of resident #012 was reviewed including the progress notes and the documentation of an identified date in May 2019, noted that referrals to an identified external service providers were in progress and the home was awaiting the completion of

identified documentation. It was noted on an identified date in May 2019, that the identified referrals were completed and faxed to the external agencies. The next day, the registered staff noted they had a discussion with the resident's SDM related to the purpose of and the need for the resident's referrals to the external agencies and the resident's SDM agreed.

Resident #012's SDM was not provided and opportunity to participate fully in the development and implementation of the resident's plan of care related to responsive behaviours during activities of daily living and in relation to referral to external resources as noted above.

This area of non-compliance was identified during Critical Incident (CI) inspection #009868-19/ CI #2948-000008-19, which was conducted concurrently with this inspection. [s. 6. (5)]

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 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, to be implemented voluntarily.

Issued on this 18th day of September, 2019

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

Original report signed by the inspector.