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
Sep 17, 2019	2019_569508_0022	013840-19, 014313-19, 017086-19	Critical Incident System

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

ROSEANNE WESTERN (508), KELLY CHUCKRY (611)

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): August 29, 30, September 4, 5, 6, 10, 11, 2019.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed resident clinical records, relevant policies and procedures and staff training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSWs) and residents.

The following Critical Incidents (CI) inspections were included in this inspection:
- 013840-19 related to falls prevention;
- 014313-19 related to responsive behaviours;
- 017086-19 related to falls prevention;

The following complaint inspection was conducted concurrently during this inspection:
2019_577611_0026

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #011 was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care which reported that resident #011 had a fall on an identified date in 2019 which resulted in an injury.

A review of the resident's clinical record, including the resident's current plan of care, assessments and the progress notes, indicated that the resident was identified as a high risk for falls upon admission.

Upon admission, the resident's interventions were developed and implemented to minimize the resident's risk for falls. A review of the resident's current plan of care indicated that the resident's falls interventions were reviewed and revised to include an additional intervention.

During an observation, it was identified that the intervention was not implemented. Interview with PSW staff #110 and #113 indicated that they were unaware of this new intervention and it had not been implemented.

During interview with ADOC #102, it was confirmed that although the CI and the current falls plan of care indicated that a new intervention had been implemented, it had not. [s. 6. (7)]

2. The licensee has failed to ensure that when the plan of care was being reviewed and revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care for resident #011.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care which reported that resident #011 had a fall on an identified date in 2019 which resulted in an injury.

A review of the resident's clinical record, including the resident's current plan of care, assessments and the progress notes, indicated that the resident was identified as a high risk for falls upon admission.

The progress notes and fall assessment tools were reviewed over an identified period which identified that the resident had multiple falls. The resident's current care plan was reviewed and it was identified that different approaches had not been considered until the resident had a fall resulting in an injury.

It was confirmed during an interview with ADOC #102 and during record reviews that the plan of care had not been effective and different approaches had not been considered in the revision of the plan of care. [s. 6. (11) (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 the care set out in the plan of care is provided to the resident as specified in the plan and ensure that when care set out in the plan is not effective, different approaches are considered in the revision of the 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.