Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: July 12, 2023	
Inspection Number: 2023-1432-0006	
Inspection Type: Complaint Critical Incident System	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 25-26, 29-31, 2023 and June 1-2, 5-8, 12-16, 2023. The following intakes were inspected:

- Intake #00019112/CI #2948-000002-23 was related to alleged abuse.
- Intake: #00087396/CI #2948-000007-23 was related to alleged abuse.
- Intake #00085608/CI #2948-000006-23 was related to falls prevention and management.
- Intake #00087374 was related to nutrition and hydration management.

The following intakes were completed in this inspection: Intake #00018761/CI # 2948-000001-23, Intake #00021056/CI #2948-000003-23, and Intake #00022622/CI #2948-000005-23 were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to revise the plan of care when a resident's needs changed for their activities for daily living (ADL).

Rationale and Summary
A resident's care plan indicated that their ADLs for transfers and mobility, which was last updated on a date in April 2023, was for extensive, two staff assistance. Inspector observed that the logo card depicting the resident's transfer status above the resident's bed was supervised independent transfer and the resident was observed self-transferring with a walker on the same day.

A PSW and RPN confirmed that the resident only required supervision with transfers, as resident is mobile with their walker. The ADOC confirmed that the resident's plan of care and the logo above their bed did not match at time of interview.

A referral for the resident was completed by the physiotherapist and they made the recommendation for the resident to receive supervised, one staff assistance with transfer. The resident's plan of care and transfer logo were updated by nursing staff to match as of June 2, 2023.

Sources: Resident and staff interviews; resident clinical records including progress notes, care plan, physiotherapy referrals and assessments; observations of resident room and transferring

Date Remedy Implemented: June 2, 2023.

[740882]

WRITTEN NOTIFICATION: Plan of Care- Involvement of Resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident or substitute decision maker (SDM) were given the opportunity to participate fully in the implementation of the resident's plan of care when an intervention was discontinued by staff.

Rationale and Summary
On a date in August 2022, a referral was submitted for the Registered Dietitian (RD) to review the nutrition and hydration status, and nutritional interventions for a resident. The resident’s plan of care was updated with nutritional interventions to help with the resident's poor intake of foods and to provide additional fluids. The RD at the time discussed with the SDM the recommended nutritional interventions to support the assessed needs of the resident and these interventions were agreed upon.

On a date in October 2022, the RD was referred to review the resident's nutritional interventions. After the RD's assessment, the resident was discontinued of certain nutritional interventions; however, neither the resident nor the SDM were contacted regarding the discontinuation of the intervention. Registered staff confirmed the home’s procedure that staff were responsible to inform an SDM of changes to ordered interventions. Staff acknowledged that based on the resident’s clinical documentation, that changes made were not discussed with the SDM or resident.

By not giving the resident and SDM the opportunity to participate in the implementation of the resident's plan of care, there was potential risk of resident’s preferences and needs not being met.

Sources: SDM and registered staff interviews; resident clinical records including progress notes, care plan, physician orders.

[740882]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect- Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #003.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to co-resident is defined as the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”).

Rationale and Summary
On a date in May 2023, there was an altercation between resident #002 and resident #003 that resulted in physical injury to resident #002.

Staff separated both residents, with redirection of resident #003 to the nursing station. However, another incident occurred shortly after, which caused an alleged injury and increased pain for resident #002.

The residents were separated, and staff had initiated monitoring of resident #003 for behaviors and checked at specific time intervals. As a result of the incident, resident #002 required wound care for injured areas, and had required increased use of pain medication as needed for pain management. The ADOC followed up with resident #002 regarding their feelings of safety and security in home. As per the inspector's interview with resident #002, they had requested for staff to monitor co-resident to continue to feel safe.

Failing to protect resident #002 from physical abuse by resident #003 caused physical injury and presented a risk to resident #002 safety.

Sources: Resident #002 and #003’s clinical records; CI Report #2948-000007-23; interviews with resident, an RPN, and the ADOC.

[740882]

WRITTEN NOTIFICATION: Conditions of the Licence

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (3)

The Licensee failed to ensure that they complied with the agreement made under the Connecting Care Act, 2019.

Rationale and Summary
Specifically, the licensee failed to ensure they complied with the practice requirements of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) system for a resident following a fall that resulted in a significant change in their condition.

On a date in April 2023, a resident sustained an injury after a fall. The resident was hospitalized and returned to the home requiring additional assistance to meet their activities of daily living (ADLs); received pain management with medication and physiotherapy involvement; utilized assistive devices for mobility, and had the initiation of fall prevention interventions.

As per the home's Long-Term Care Home Service Accountability agreement (LSAA) under the Connecting Care Act, 2019 (CAA), the licensee was required to meet the practice requirements of the RAI-MDS system, which included conducting quarterly assessments of residents at the home, and all other assessments of residents required by the RAI MDS Tools, using the RAI MDS Tools.

The home did not meet the criteria for determining a significant change in the status for the resident and did not use the RAI-MDS tool correctly to produce an accurate assessment of the Health Care Service Provider's residents (RAI-MDS Data). The RAI Coordinator verified that the RAI-MDS assessment for a significant change was not opened and should have been initiated after the resident returned from hospital.

As the resident's injury impacted more than one area of their health status, there was potential risk to the resident not receiving appropriate reassessment of care needs by the inter-disciplinary team.

Sources: Resident clinical record including progress notes, care plan, RAI-MDS assessments, electronic medication administration record; the LSAA dated April 1 2023- March 31, 2024, for MULTI-HOMES, with 955464 Ontario Limited, Effective Date: April 1, 2023; the home's policy titled "Quarterly MDS RAI review" dated February 28, 2020, index number CN-Q-01; Resident Assessment Instrument (RAI) MDS 2.0 User’s Manual, Canadian Version, February 2012; interviews with RAI Coordinator and other staff.

[740882]

WRITTEN NOTIFICATION: Care Conference

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (c)

The licensee had failed to ensure that a record was kept of the date, the participants, and the results of conference.

Rationale and Summary
Specifically, the home did not ensure the record for a resident's annual care conference contained the results of the conference, including SDM comments/concerns and issues/decisions made during the conference. During the annual care conference for the resident, their SDM had stated specific concerns regarding care.

The staff present during the meeting confirmed that comments regarding resident care were mentioned by the SDM during the care conference, but it was not documented as required for the Interdisciplinary Team Care Conference. The DOC confirmed the results of the SDMs concerns and actions to address those concerns were not documented.

There was potential risk of the resident care need concerns from the SDM not being addressed when results of the care conference were not documented.

Sources: Resident clinical records including progress notes, and "Interdisciplinary Care Conference V-4" Assessment; interviews with SDM, DOC and other staff.

[740882]

WRITTEN NOTIFICATION: General Requirements for Required Programs-Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that a pain assessment for the resident as per the home's pain management program was documented.

Rationale and Summary

As part of the home's pain management program, the policy titled Pain Identification and Management indicated that a pain assessment must be completed electronically for the indication of presence of pain (including reported pain) in a resident. The ADOC confirmed that the assessment titled Pain/Palliation-

NEW Pain Assessment is to be completed and documented electronically when the resident demonstrates or complains of a new onset of pain.

On a date in April 2023, the resident had a fall that resulted in hospitalization and treatment for an injury. The resident returned from hospital with pain management interventions for their acquired pain.

On a date in May 2023, the resident reported severe pain to a staff member. The registered staff member assessed the resident and provided pain medications but did not document the assessment.

The registered staff member confirmed that though they assessed the resident and provided the pain medication, the pain assessment and management was not documented on that day of incident.

The ADOC confirmed that there was no documentation for the resident’s pain assessment being completed when there was a complaint of pain, and that it should have been completed during the shift of the registered staff.

By the resident’s comprehensive pain assessment not being documented at time of shift, it put resident at potential risk for remaining in pain and further follow up from staff not being completed.

Sources: Interview with resident, staff; resident clinical record; the home's policy titled Pain Identification and Management, revised date March 2023, index number RC-19-01-01.

[740882]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4. ii.

The Licensee failed to include the analysis and follow up action of the long-term actions planned to correct the situation and prevent recurrence regarding the report made to Director of alleged resident to resident abuse.

Rationale and Summary
On a date in January 2023, the alleged unwitnessed abuse of a resident occurred, which resulted in the hospitalization of the resident. The long-term care home (LTCH) submitted a critical incident report (CI)

and did not update the CI with long-term actions planned following internal investigation.

A PSW and RPN confirmed interventions were put in place for both residents after the incident. The DOC confirmed that the CI was filed for suspect of physical abuse and should have been updated following the LTCHs investigation.

Sources: Interviews with a PSW, RPN, and DOC; resident clinical records; internal follow up investigation notes; CI #2948-000002-23.

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