Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 19, 2023	
Inspection Number: 2023-1432-0007	
Inspection Type: Complaint Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature**
Additional Inspector(s) Jonathan Conti (740882)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21, 23-24, and 27-30, 2023, December 1 and 4, 2023.

The following intake(s) were inspected:

- Intake: #00097442 for a Complaint related to resident rights, prevention of abuse and neglect, staff training, and responsive behaviours.
- Intake: #00098775 for a Complaint related to staffing and nursing and personal support services.
- Intake: #00098950 for a Critical Incident (CI) related to physical abuse.
- Intake: #00100868 for a CI related to fall prevention and management.
- The following intake(s) were completed in this inspection:
  Intake #00096769- CI related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
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)
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of Care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's use of a piece of equipment was documented as set in their plan of care.

Rationale and Summary
During the course of inspection, a resident's bed was observed to have a piece of equipment in place. The resident's electronic medical records (EMR) did not indicate the use of the equipment in their care plan. On a specified date, the Assistant

Director of Care (ADOC) stated that the resident used the equipment as a fall prevention intervention and acknowledged their care plan did not have the intervention documented. On the same day, the resident's care plan was updated with the use of the equipment.

Sources: Observations, a resident's records, and an interview with the ADOC.

Date Remedy Implemented: November 29, 2023 [740765]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (9) 3.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
3. The effectiveness of the plan of care.

The licensee has failed to ensure that the effectiveness of the plan of care was documented.

Rationale and Summary
A resident had a history of a specific behaviour that caused altercations with a co-resident as documented on specified dates. Interventions were put in place related to the resident's specific behaviour which included a specified intervention to prevent further altercations.

During observations, the resident's specified intervention was not in place.

The ADOC acknowledged that progress notes on a specified date, indicated that the specified intervention was agreed upon with the substitute decision maker (SDM) and would be in place. As per the ADOC, the intervention was no longer necessary as it was ineffective and was not documented.

During the course of inspection, a progress note documentation was in place regarding the ineffectiveness of the specified intervention, and the ADOC had informed the SDM following an interview with this inspector.

Sources: Two residents' clinical records including progress notes, observations and interview with staff including the ADOC.

Date Remedy Implemented: December 1, 2023 [740882]

WRITTEN NOTIFICATION: Training and Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 262 (2)
Exemptions, training
s. 262 (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

The licensee has failed to ensure that their Agency staff were provided with information about items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

In accordance to FLTCA, s. 82 (2), paragraphs 1, 3, 4, 5, 7, 8, and 9 information items mentioned included:

- The Residents' Bill of Rights.
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 28 to make mandatory reports.
- The protections afforded by section 30.
- Fire prevention and safety.
- Emergency and evacuation procedures.
- Infection prevention and control.

Rationale and Summary

The home's orientation and training included the utilization of an online platform called Surge Learning. All areas listed in subsection 82 (2) of the Act were included in their Surge Learning as mandatory education for staff to complete on orientation and annually.

The Director of Care (DOC) explained that all staff, including Agency staff, completed all mandatory education in Surge Learning prior to accepting a shift. Agency staff received a minimum of eight hours shift training on the floor as well. The DOC was unable to provide the Surge Learning records or any learning information packages provided for their Agency staff.

During the course of inspection, three Agency staff acknowledged they did not receive any formal training or provided any information of the required items mentioned in the Act from the home. They stated they did not receive training on an online platform, nor were they given access, and were not aware of what Surge Leaning was. They explained they had only received training on the floor with a regular staff of their daily job routines and stated they did not review nor receive information of the areas listed in the Act during their training shift. An Agency staff indicated they never received any information package or education materials from their Agency that came from the home.

The DOC later explained that their Corporate Head Office (CHO) provided their Agencies with the mandatory education items to provide to their staff to complete prior their on the floor training. They stated their CHO maintained those training records and would provide them to the inspector. No records were provided upon the completion of inspection activities.

Failure to ensure that Agency staff received information under the areas listed in the Act before providing their services posed risks for resident safety and well-being.

Sources: Training records, Surge Learning modules, and interviews with Agency staff and the DOC. [740765]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

The licensee has failed to comply with the strategy to monitor a resident after their fall.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee was required to ensure the falls prevention and management program, at a minimum, provided strategies including the monitoring of residents, and must be complied with. Specifically, staff did not comply with home's documentation requirements in the clinical monitoring record as per the home's "Falls Prevention and Management Program."

Rationale and Summary
A) On a specified date, a resident had an unwitnessed fall, and a clinical monitoring record was not completed for two different shifts' hourly Neuro-Checks. No documentation in the resident's clinical record was noted for the required assessments that should have been completed during a specified date shift as well.

B) On a specified date, the resident had another unwitnessed fall with a sustained injury, and the clinical monitoring record was not completed one shift of the hourly Neuro-Check.

According to the home's policy, for every resident who hits their head or is suspected of hitting their head (e.g. unwitnessed fall), a post-fall 72 hours assessments and clinical monitoring record were to be completed.

The ADOC and a registered staff stated that the expectation was that a clinical monitoring record was required to be completed for all nine shifts after an unwitnessed fall. Staff acknowledged that the clinical monitoring record was not completed for all shifts for the stated falls.

As a result, there was a potential safety risk to the resident when the clinical monitoring record was not completed due to potential new changes may not have been monitored appropriately.

Sources: A resident's clinical assessments and progress notes, the home's Falls Prevention and Management Program, and an interview with the ADOC and a registered staff. [740882]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that when a resident had a fall, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
On a specified date, a resident had an intercepted fall, where the resident was assisted to the ground by staff. The resident's clinical records did not indicate a

post-fall assessment was completed. The DOC and the ADOC both explained that post-fall assessments were to be completed with intercepted falls where the resident was lowered to the ground or other lower level. They both acknowledged that a post-fall assessment was not completed for the resident.

Failure to ensure a post fall assessment was completed posed a risk for not identifying any potential harm and implementation of interventions for the resident.

Sources: A resident's clinical records, Falls Prevention and Management Program, and interviews with the DOC and ADOC. [740765]

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically for pain.

Rationale and Summary

On a specified date, a resident had a fall and sustained skin alterations. The following day, the resident demonstrated signs and symptoms of pain and was ordered a new as needed pain medication. The resident's clinical records indicated they received the new pain medication for four consecutive days when needed. They did not have a pain assessment completed during this time.

The ADOC acknowledged that the resident should have had a pain assessment

completed when they had the fall, when the resident had new and worsening pain, and when they had new pain medications initiated.

Failure to ensure a pain assessment was conducted for the resident posed a risk for not identifying any potential harm and the implementation of interventions.

Sources: A resident's clinical records, Pain Identification and Management Policy, and an interview with the ADOC. [740765]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(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.

The licensee has failed to ensure that a resident's monitoring of their behaviours using the home's Dementia Observation System (DOS) was fully documented.

Rationale and Summary

On a specified date, a resident was initiated on DOS monitoring. The resident's DOS data collection sheet from specified dates had incomplete documentation on multiple shifts and times. The DOC acknowledged the resident's DOS data collection had incomplete documentation.

Failure to complete the DOS data collection sheet posed a risk to the resident's potential responsive behaviours that may have required follow-up, not being identified.

Sources: A resident's clinical records and interview with the DOC. [740765]

WRITTEN NOTIFICATION: Food Service Workers, Minimums

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 83 (1)

s. 83 (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,

(a) the preparation of resident meals and snacks;

(b) the distribution and service of resident meals;

(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and

(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 246/22, s. 83 (1).

The licensee has failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours per week as calculated under subsection (2) of the regulations.

As per O. Reg. 246/22, s. 83(2),

"(2) For the purposes of subsection (1), but subject to subsection (3), the minimum staffing hours shall be calculated as follows:

M = A x 7 x 0.45

where,

"M" is the minimum number of staffing hours per week, and

"A" is, at the option of the licensee, either,

(a) the licensed bed capacity of the home for the week, excluding beds not available for occupancy pursuant to a Minister's directive, Ministry policy or otherwise at law, or
(b) the number of residents residing in the home for the week, including absent residents."

Rationale and Summary
The home had a calculated minimum number of staffing hours for food service workers of 504 hours (hr) per week. The Food Service and Nutrition Manager (FSNM) confirmed that the home's minimum calculations are based on the licensed bed capacity of the home for the week.

The minimum number of hours calculated by inspector 740882 utilizing the formula provided in legislation, resulted in the same required minimum 504 hours per week.

As per the FSNM, the home was to exceed this minimum staffing hours with a weekly calculated 507 hours on site per week for food service workers based on a full operational schedule.

As per interviews with staff, during specified months, there were staffing shortages that impacted the home meeting the minimum number of staffing hours as per legislation.

On review of the provided timesheets for food service workers from the period of specified dates, the minimum hours for the following four weeks were not met:

Specified week date: 501.77hrs/week
Specified week date: 473.15hrs/week
Specified week date: 487.06hrs/week
Specified week date: 488.03hrs/week

The FSNM acknowledged that the food service departments staffing protocol was put in place to cover the food service worker related duties, however confirmed that the staff shortages for the above mentioned weeks resulted in not meeting the calculated minimum staffing hours. The FSNM identified that coverage attempts were made during those weeks, however there would be instances where some shifts worked short.

As a result, there was a potential risk for food service worker duties not being met due to additional workload requirements for staff covering duties, and potential for resident care being impacted.

Sources: Interviews with staff and the FSNM, the homes' policy titled "Scheduling Hours", job routines, the homes dietary department staffing protocol, dietary department staffing schedules and pay schedules, and the home's minimum staffing hours calculations. [740882]

COMPLIANCE ORDER CO #001 Communication and Response System

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20 (f) clearly indicates when activated where the signal is coming from;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Provide education to all nursing staff working on a specified resident home area (RHA) regarding the home's resident-staff communication and response system and accountability of pager use.

2. Maintain written records of the education provided and the list of staff who received and completed the education. All written records must be available on request.
3. Complete daily audits for every shift on a specified RHA for two weeks for staff sign out and in of pagers. Audits must be maintained and available on request.

Grounds

The licensee has failed to ensure that the resident-staff communication and response system (RSCRS) clearly indicated when activated where the signal was coming from.

Rationale and Summary
A complaint was lodged that staff were not attending to residents when they activated their call bells. The home's RSCRS is connected with pagers which indicate an audible signal and display the location where the system was activated.

On a specified date and a specified RHA, four direct care staff were observed in the dining room assisting residents during the end of a meal service. During this time, two pagers were observed in a corner basket of the nursing station counter and were not in the possession of the staff working. Both the pagers were activated with an audible signal and display of activation location by two residents who had left the dining room after their meals. A review of the specified RHA pager sign in and out sheets from specified dates, indicated multiple shifts and pagers were not accounted for by direct care staff and checked by registered staff.

The DOC and ADOC both acknowledged that the pager sign in and out sheets had missing signatures and it was the expectation that the staff were to wear the pagers and sign for the possession of them at the start of their shift and the return at the end of their shift. Registered staff working were also expected to sign the pager

sheets to ensure the pagers were in the possession of the direct care staff. The ADOC explained there were four pagers in each RHA and that all of the four direct care staff should have been wearing them when working during the time of observation. The DOC stated that staff not wearing pagers placed a risk for residents with prolonged waiting responses and needs not being met.

Failure to ensure direct care staff were wearing pagers that indicated where the RSCRS signal was coming from when activated put residents' safety and well-being at risk.

Sources: Observations in a specified RHA, RHA Pager Sign Sheets, and interviews with the ADOC and DOC. [740765]

This order must be complied with by March 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with FLTCA, 2021, s. 20 (f), resulting in a CO in inspection #2022-1432-0003 issued on January 3, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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