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
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Original Public Report

Report Issue Date: June 24, 2024	
Inspection Number: 2024-1432-0002	
Inspection Type: Complaint Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls	
Lead Inspector Nishy Francis (740873)	**Inspector Digital Signature**
Additional Inspector(s) Emily Robins (741074) Meghan Redfearn (000765)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14 - 17, 21 - 24, 27, and 28, 2024.
The inspection occurred offsite on the following date(s): May 21, 2024.

The following intake(s) were inspected:
- Intake: #00101923 (CI: 2948-000027-2) related to falls prevention and management;
- Intake: #00104260 (CI: 2948-000031-23) related to prevention of abuse and neglect;
- Intake: #00108697 (CI: 2948-000010-24) related to prevention of abuse and neglect;

- Intake: #00110066 (CI: 2948-000012-24) related to prevention of abuse and neglect;
- Intake: #00111533 (CI: 2948-000014-24) related to prevention of abuse and neglect;
- Intake: #00109870 (complaint) related to resident care and services and falls prevention and management.

The following intakes were completed in this inspection:
Intake: #00102516 (CI: 2948-000028-23), intake: #00104010 (CI: 2948-000030-23), intake: #00112067 (CI: 2948-000015-24), and intake: #00110266 (CI: 2948-000013-24) related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (7)
Plan of care

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.

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

Rationale and Summary
On a specified date, a staff acknowledged a resident's personal assistive device was not working. The resident's plan of care required staff to verify that the personal assistive device was on and in working order at least daily. The staff stated they were to correct the personal assistive device when it was not on and in working order and acknowledged they had not completed either.

Another staff reset the personal assistive device and ensured it was on and in working order during a follow up observation.

When the personal assistive device was not on and in working order, there was potential risk of injury and delay in treatment.

Sources: Observations; interview with staff; resident's clinical record. [740873]

Date Remedy Implemented: May 14, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that the resident was reassessed, and the plan of

care reviewed and revised when the care set out in the plan has not been effective.

Rationale and Summary
The resident's plan of care indicated they required falls prevention interventions.

Staff interviews, observations and progress notes indicated that the implementation of the intervention was not effective. Staff acknowledged the plan of care was not reassessed or reviewed when the interventions were ineffective.

During follow up observations, the home had implemented the interventions effectively.

When the plan of care was not reassessed or reviewed when the care set out in the plan has not been effective, there was a potential risk towards the resident's safety.

Sources: Observations of resident's room; interviews with staff; resident's clinical record. [740873]

Date Remedy Implemented: May 15, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary

The resident had a fall on a specified date. The plan of care stated they required a personal assistive device as a falls prevention strategy. The Associate Director of Care confirmed the resident did not have a personal assistive device in place at the time of the fall and that it should have been in place.

The resident had another fall on a specified date. A staff verified the personal assistive device was not in place at the time of the fall and confirmed it should have been in place.

When care was not provided as per the plan of care, there was actual harm to the resident on two separate incidents. When the home continued to fail to provide care as per the plan of care after the first fall, the resident sustained further harm and did not receive the care required to reduce the incidence of injury.

Sources: Interviews with staff; review of resident's clinical record. [740874]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A staff alleged that a direct care staff neglected to provide care for a resident on a specified date. The staff did not report this suspicion and the information upon which it was based to management until a later date, at which point it was reported to the Director.

Sources: Critical Incident Report #10-24 and interviews with staff. [741074]

(2) The licensee has failed to ensure that an incident of suspected resident to resident physical abuse that resulted in harm to a resident was immediately reported by staff to management.

Rationale and Summary
On a specified date, resident #003 had an unwitnessed fall into the hallway from resident #004's room, which resulted in altered skin integrity.

Staff stated when they responded to the fall they heard resident #004 state that they had pushed resident #003, and heard resident #003 state that resident #004 had pushed them.

The homes Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy stated an employee who becomes aware of an alleged, suspected or witnessed resident incident of abuse will report it immediately to the Administrator, Designate, or Reporting Manager, or if unavailable, the most senior supervisor on shift at that time.

Staff stated they reported the incident to a registered staff member. The registered staff acknowledged suspected abuse required immediate reporting to management, and was unsure if they had reported the incident to management.

The Director of Care (DOC) stated they were not informed about the suspected

incident of physical abuse and that if staff suspected physical abuse then it should have been reported immediately to management.

There was risk that an incident of alleged physical abuse would not be investigated when staff did not report it to management.

Sources: Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; CI Report; resident #003's progress notes; interviews with staff. [000765]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment upon any return of the resident from hospital.

Rationale and Summary
A resident had a fall where they sustained altered skin integrity and were transferred to the hospital. A staff stated that a skin assessment was not completed when the resident returned from the hospital and should have been completed.

When a skin assessment was not completed for the resident upon return from the hospital, there was a risk of staff being unaware of potential skin deterioration.

Sources: Interview with staff; review of resident's clinical record. [740873]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that interventions to minimize the risk of altercations and potentially harmful interactions between and among residents were implemented.

Rationale and Summary
The resident's care plan indicated an intervention to be in place when the resident was not in their room to deter co-residents from wandering in. A registered staff stated the resident dislikes when people are in their room and will get protective of their space.

Observations of the resident's doorway and room were made during the inspection. The intervention was not implemented.

The staff stated they had not seen the intervention in place and acknowledged it was not in place. They also stated if the intervention was listed in the resident's care plan, then it should be in place.

There was a risk that a co-resident could wander into the resident's room when the intervention was not in place.

Sources: Observations of resident's room; resident's plan of care; interviews with

staff. [000765]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary
A resident had a fall on a specified date where they sustained an injury and were transferred to the hospital. The injury required further intervention, impacted more than one aspect of the resident's health condition and there were revisions to the resident's plan of care.

The home's management agreed based on the definition of significant change under FLTCA 2021 s. 115 (8) that resident's fall should have been reported as a critical incident and was not.

When the home fails to adhere to reporting guidelines, there is a risk that information is not accurately captured for trending purposes. Failure to report the incident to the Director had low impact and risk to the resident.

Sources: Interview with the Administrator; review of resident's clinical record. [740873]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

(1) Provide education to the following staff:
- Four identified staff on the process for how to respond to alleged, suspected, or witnessed abuse of residents, including the requirement to comply with mandatory reporting; and
- An identified staff on the home's policy pertaining to the prevention of abuse and neglect, specifically the definition of neglect and any aspects pertaining to ensuring residents are not neglected by staff; and
- Two identified staff on the home's policy pertaining to the prevention of abuse and neglect, specifically the definition of emotional abuse; and
- Document the education, including the dates, names of staff receiving education, and the staff member(s) who provided the education; and

(2) Perform audits to ensure an identified staff is providing care as required to residents on night shift and keep a record of these audits for inspector review; and

(3) Complete a review of resident #004's behaviours focus in their care plan. Reassess the interventions related to behaviors and ensure that new interventions are implemented to reduce the risk of further altercations.

- Ensure the effectiveness of interventions is reassessed; and
- Keep a written record of the review, any changes to interventions, and the effectiveness of the interventions.

Grounds

(1) The licensee has failed to ensure that resident #003 was protected from physical abuse by resident #004.

Rationale and Summary
O. Reg 246/22 s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On a specified date, resident #003 had an unwitnessed fall from resident #004's room into the hallway, which resulted in altered skin integrity. A summary of the video footage from the incident indicated resident #004 was observed entering their room, followed by resident #003 a few minutes later. Resident #003 was then observed quickly falling into frame from the threshold of resident #004's room.

Two staff attended to the residents, separated them and completed their assessments.

Staff acknowledged that there was physical abuse of resident #003.

Failure to protect resident #003 from physical abuse resulted in injury to the resident.

Sources: Resident #003's progress notes; resident #004's progress notes; interviews with staff. [000765]

(2) The licensee has failed to ensure that a resident was protected from emotional abuse by a staff member.

Rationale and Summary
O. Reg. 246/2,2 s. 2 (1) (a) defines emotional abuse as any humiliating gestures including infantilization that are performed by anyone other than a resident.

A staff was reported video recording a resident using their personal cellphone and making audible sounds of a humiliating nature. The home's video surveillance and the DOC indicated that the staff's cellphone was directed towards a resident and the staff was making facial expressions of a humiliating nature towards the resident.

When the home fails to protect a resident from emotional abuse by a staff member, there is a risk of harm to the resident's well-being.

Sources: Interviews with staff; home's investigative notes. [740873]

(3) The licensee failed to ensure that the resident was not neglected by staff.

Section 7 of O. Reg. 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary
A resident required monitoring through the night. On a specified date, a staff was assigned to the resident's care. The staff did not check that the resident was safe, nor did they check other care items as was required per their plan of care overnight.

The resident was found by on-coming staff the next morning in an unsanitary condition. The overnight staff falsely documented that they monitored the resident, completed safety checks as scheduled, and provided care during their shift.

Failure to ensure the resident was not neglected by staff caused actual harm to resident.

Sources: Critical Incident Report (CIR) #10-24, resident's care plan, progress notes, documentation survey report, and assessments, the home's investigation notes related to CIR #10-24, and interviews with staff. [741074]

(4) The licensee failed to protect a resident from emotional abuse from staff.

Section 2 of O. Reg. 246/22 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Rationale and Summary
A resident required the assistance of two staff for care. On a specified date, the resident rang for assistance. A staff responded and indicated that they could not provide assistance and suggested an alternative option that was contraindicated. The resident was very upset as a result of this interaction with the staff and indicated that this was not acceptable to them.

Failure to ensure that the resident was protected from emotional abuse by the staff caused emotional harm to the resident.

Sources: Resident's progress notes, care plan, and assessments, risk management incident #5167, the home's investigation notes for Critical Incident #12-24, and interviews with staff. [741074]

This order must be complied with by August 5, 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 $5500.00, 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:

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.