Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2013	2013_105130_0023	H-000483-13	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

GILLIAN TRACEY (130)

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): August 22, 2013

During the course of the inspection, the inspector(s) spoke with The Director of Care, Assistant Directors of Care (ADOC), Registered Staff, personal support workers and residents.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records, reviewed investigative notes and reviewed protocols related to H-000483-13.

Ad-hoc notes were used during this inspection.

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure that the provision of care set out in the plan and the effectiveness of the plan of care was documented.

a) In 2013, resident #001 received a dose of an identified medication by injection due to a report of illness. The ADOC confirmed that staff did not record the resident's abnormal symptoms as initially reported by front line staff, did not record the medication administered by mouth or by injection and did not record the effectiveness of the medication until at least a month later, when a request was made by the ADOC to record the late entry.

b) According to the MAR, resident #002, was administered a medication on an identified date in 2013, in accordance with the home's medical directive. According to the MAR, progress notes and staff interviewed, the medication administered was not signed for on the MAR to indicate it was given, nor was there documentation per the home's protocol, to indicate the effectiveness of the drug. [s. 6. (9)]

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 provision of care set out in the plan and the effectiveness of the plan is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

a) The home's Medical Directive indicated that registered staff may administer 50 mg po or IM (by mouth or injection) of an identified medication every 4 hours prn (as needed) x 24 hours, when clinically indicated. In 2013, resident #001 was administered 25 mg of the medication by mouth, for a report of illness, however, the resident refused the oral dose, therefore staff administered 25mg by injection. The ADOC confirmed staff did not deliver the correct dose by mouth nor by injection. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions from use as specified by the prescriber, to be implemented voluntarily.

Issued on this 26th day of August, 2013

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