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
Dec 30, 2013	2013_214146_0068	H-000727-13,H-000564-13	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

BARBARA NAYKALYK-HUNT (146)

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): December 18, 19, 20 2013

This inspection was conducted for two complaints H-000564-13 and H-000727-13. Inspectors Roseanne Western and Susan Porteous were in attendance.

During the course of the inspection, the inspector(s) spoke with the administrator, Director of Care (DOC), RAI (Resident Assessment Instrument) coordinator, registered staff, Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) toured the home; reviewed the home's policies and procedures related to falls management, medication administration, skin and wound care; reviewed resident health records; observed residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out (c) clear directions to staff and others who provided direct care to the resident.
(A) Resident #001's current December care plan indicated that staff were to apply a specific intervention. A physician's order directed that the intervention be discontinued in October 2013. The resident did not receive the intervention when observed on December 19, 2013 and, according to the health record, had been refusing the intervention. This information was confirmed by the health record, observation and the DOC. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
(A) Resident #001's care plan specified that one half rail was to be in the raised position. In September 2013, a progress note indicated that both bed rails were in the raised position. In October 2013, an occurrence report documented that both bed rails were up.
(B) Resident #001's care plan specified that the resident was to have a specific intervention in place. When observed in December 2013, the intervention was not in place.
(C) Resident #008's care plan indicated that one bed rail was to be raised. When observed in December 2013, both bed rails were raised.
(D) Resident #002's care plan indicated that a specific intervention was to be in place when up in chair. When observed in December 2013, the resident was in a chair without the specified intervention.
This information was confirmed by health records and observation. [s. 6. (7)]

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
(A) In December 2013 resident #008's an assessment tool indicated that a specific intervention should be used. The intervention was observed to be in place in December 2013 however, no documentation related to the intervention could be found in the progress notes, care plan or kardex. The DOC confirmed that the expectation of the home would be that the intervention would be documented.
(B) Bathing documentation was reviewed on the flow sheets for the months of September, October and November 2013 for four residents: residents #002, 003, 004 and 005. The DOC confirmed that the expectation of the home was that baths be documented on the flow sheets. The documentation indicated that at least one third of the baths were not documented for those four residents during the three month period. This information was confirmed by the health record and the DOC. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.
Resident #001 had several documented falls in a two month period; two of the falls resulted in serious injury. No post fall assessments were completed after 50% of the falls.
This information was confirmed by the health record and the DOC. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to notify the Director no later than one business day after the occurrence of an incident:
4. that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.
Resident #001 sustained an injury which required transfer to hospital. The resident returned from hospital with a revision to the care plan. Since the resident required further intervention before resolution could occur and a revision to the plan of care was required, the incident resulted in a significant change in the resident's health condition and should have been reported in a critical incident. A critical incident was not submitted by the home. This information was confirmed by the health record, the administrator and the DOC. [s. 107. (3)]

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Issued on this 30th day of December, 2013

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

BARB NAKONYK