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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_323130_0008	H-002381-15	Resident Quality Inspection

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), CATHY FEDIASH (214), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 30, May 1, 4, 5, 6, 8, 12, 13, 14, 19, 20, 21, 2015.

Please note: the following inspections were conducted simultaneously with this RQI: H-001717-14, H-001456-14, H-001508-14, H-001744-14, H-001942-15, H-002363-15, H-002163-15, H-002204-15, H-000804-14, H-000859-14, H-000845-14, H-001134-14, H-001161-14, H-001211-14, H-001397-14, H-001462-14, H001425,14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers (PSWs), Manager of Housekeeping/Laundry, Manager of Maintenance Services, dietary staff, housekeeping staff, President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

15 WN(s)
10 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

a) The quarterly Minimum Data Set (MDS) section G.-Physical Functioning and Structural Problems, completed for resident #108 on a specified date in 2015, indicated that for toilet use, the resident required extensive assistance of two or more persons physical assistance. A review of the resident's written plan of care on a specified date in 2015, indicated under toilet use that the resident required total assistance of one person. An interview with the RAI Coordinator confirmed that the resident did require extensive assistance of two or more persons physical assistance for their toileting needs and that their plan of care was not based on an assessment of the resident's needs. (Inspector #214) [s. 6. (2)]

2. 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.

a) Resident #506 had responsive behaviours that included verbal and physical

aggression towards co-residents. On an identified date in 2014, resident #506 was witnessed touching a co-resident in an inappropriate manner. One to one staffing was implemented to minimize the risk of further incidents of responsive behaviours towards co-residents. Two days later, resident #506 pushed a co-resident when the co-resident was standing close to them. The staff member responsible for monitoring resident #506 had left the unit for a break and during this time resident #506 was not being monitored and no staff intervened to prevent this occurrence.

It was confirmed by the DOC that care set out in the plan of care was not provided to resident #506 as specified in the plan. (Inspector #508)

b) Resident #400 sustained an injury from a fall on a specified date in 2014. The resident complained of pain to specific areas post fall for which x-rays were ordered by the Physician. A Diagnostic Imaging Report dated after the fall in 2014 indicated there were no new injuries; however, the report indicated "if symptoms persist, a follow up is recommended". This information was communicated in the plan of care. Progress notes and pain assessments completed over a three month period in 2014 indicated the resident continued to demonstrate increased pain and required increased analgesics. Follow-up x-rays were not obtained until a later date in 2014, which showed an injury to a specific area. The ADOC reviewed the record and confirmed that care was not provided to the resident as specified in the plan. (Inspector #130)

c) Resident #201 did not receive care as specified in the plan of care when it was noted that the resident was provided pureed bread at the noon meal on an observed day in 2015. The PSW providing the resident with assistance at this meal indicated to the Inspector that they were aware the resident was not to have bread. The dietary serving staff indicated that the resident could have the bread because sometimes the resident's spouse allowed the resident to have bread. The dietary serving staff confirmed that the dietary kardex directed that the resident was not to be given bread and dietary directions in the resident's plan of care directed that the resident was not to have bread at the family's request.

d) Resident #202 was observed during the noon meal on an identified date in 2015 to take a co-resident's glass of milk. The PSWs assisting in the dining room were provided with this information and provided the co-resident with another glass of milk, but did not remove the glass of milk taken by resident #202. Resident #202 drank the glass of milk belonging to the other resident. It was verified by staff that the milk taken by resident #202 was regular milk. The dietary server confirmed that resident #202 was not to have

regular milk as specified in the plan. (Inspector #129) [s. 6. (7)]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following:

a) Resident #103's plan of care was not reviewed and revised when clinical documentation indicated the resident began to fall. Clinical documentation indicated the resident fell five times over a two month period in 2015. Care interventions initiated in 2014 in order to meet the identified goal that the resident would be free of falls, included: the use of one bed rail while in bed, staff were to check the resident every hour for safety, staff were to encourage the resident to use handrails or assistive devices, ensure a clutter free environment and a fall mat beside the bed. The RAI Coordinator confirmed that resident #103's plan of care was not reviewed or revised when the resident began falling and fell five times over a 52 day period of time.

b) Resident #103's plan of care was not reviewed or revised when clinical documentation indicated the resident began demonstrating altered skin integrity. A skin assessment completed on a specified date in 2015, indicated that the resident's family reported an area of skin impairment to a specified area.

Staff and clinical documentation confirmed that the resident sustained an area of skin impairment to a specified area on an identified date in 2015, that required assessment and treatment in hospital as a result of a fall. A registered practical nurse (RPN), providing care to the resident, confirmed that although the resident's plan of care indicated a risk for pressure ulcers, there were no care directions for staff in the management of current skin integrity issues, care to prevent further injuries to the resident's skin or hygiene care in relation to the current areas of altered skin integrity.

c) Resident #111's plan of care was not reviewed and revised when data collected on a RAI-MDS assessment completed on an identified date in 2015, indicated the resident's urinary continence status had deteriorated since the last review and the resident was now frequently incontinent of urine. Staff and clinical documentation confirmed that the goal of care remained that the resident would be continent and there were no changes to the care interventions for this resident.

d) Resident #108's plan of care was not reviewed and revised when data collected on a RAI-MDS assessment completed on an identified date in 2015, indicated the resident's

mood and behavioural symptoms had deteriorated over the last 90 days. The data collected indicated several different responsive behaviours. The resident was also experiencing changes in their usual sleep pattern and repetitive physical movements on an almost daily basis. Staff also documented that the resident was demonstrating verbally abusive behaviours almost daily and these behaviours were not easily altered. The associated RAP completed following this data collection did not include any rationale for care planning based on the noted deterioration in the resident’s mood and behaviour symptoms.

Staff interviewed confirmed that the resident’s plan of care was not reviewed or revised and there were no care directions for staff in the assessment or management of these mood and behaviour changes. (Inspector #129)

e) Resident #507 had been identified as having a specific responsive behaviour. On an identified date in 2014, resident #507 had increased confusion and was demonstrating this responsive behaviour. The following month, the responsive behaviour increased and the resident remained confused. The resident was on medication to treat an infection that may have contributed to an increase in the resident's confusion. The following month in 2014, the resident wandered outside of the building without appropriate clothing for the outside temperatures. The resident was discovered by co-resident and redirected the resident back into the home.

A review of the resident's plan of care indicated that during the time that the resident had increased confusion and these behaviours, the plan of care had not been reviewed and revised until after the identified incident occurred in 2014.

It was confirmed by the RAI Coordinator that the resident's plan of care was not reviewed or revised when the resident's care needs changed. (Inspector #508) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #505's rights were fully promoted and respected when the resident was not protected from abuse.

a) Resident #505 had an identified diagnosis and responsive behaviours that included being resistive to care.

It was reported by a staff member that on an unidentified date in 2014, they had witnessed another staff member physically harming resident #505 and yelling at the resident to stop hitting them.

The staff member who witnessed this incident reported this to registered staff and the registered staff reported the incident to the Director of Care. The staff member involved in this incident was terminated for abuse.

It was confirmed during an interview with the Director of Care on an identified date in 2015, that resident #505 was not protected from abuse. (Inspector #508) [s. 3. (1) 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 all residents are protected from abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

a) A review of the home's policy titled, Skin Care And Wound Care Program CN-S-13-1 and dated June 2010, indicated the following:

i) Under "Skin Assessments", Personal Support Workers (PSW) to assess skin integrity daily during activities such as dressing, toileting and bathing paying particular attention to bony prominences and vulnerable areas. PSW's shall report any altered skin integrity or concerns to the Registered staff.

On two identified dates in 2015, resident #102 was observed to have an alteration in skin to an identified area. An interview with a registered staff member and PSW confirmed that they were not aware of this. An interview with the registered staff, PSW and the DOC confirmed that front line nursing staff were expected to assess the resident's skin integrity daily during care and to report any alteration in skin to the registered staff as well as to document on the PSW Minimum Data Set (MDS) Flow Sheets, under Other Health Conditions - Abrasions/Bruises/Wound. A review of the PSW MDS Flow Sheets over a seven day time period in 2015, indicated that the resident's skin alteration had not been documented on these flow sheets. The DOC confirmed that the home's policy had not been complied with. (Inspector #214)

b) Staff did not comply with the directions contained in the "Falls Prevention and Management Program", identified as CN-F-05-1 and dated June 2010.

The policy directed that post falls evaluations will be conducted on residents who fall and ongoing changes made to the care plan as needed. Staff did not comply with this direction when post fall evaluations completed for resident #103 did not include ongoing changes made to the care plan as needed. The resident fell twice on five known occasions in 2015 and post falls evaluations did not include ongoing changes made to the care plan.

The policy directed that the assessment of fall risk needed to be multi-factorial and multidisciplinary. The DOC confirmed that assessments would completed by the physiotherapist. The DOC confirmed that physiotherapy staff were not involved in the assessment of resident #103's falls and that the policy was not complied with.

The policy directed that an evaluation is conducted to determine success of fall prevention strategies after a fall. Staff and clinical documentation confirmed that there was not an evaluation conducted to determine the success of fall prevention strategies in place after resident #103 fell on five occasion in 2015.

The policy directed that a summary of findings and actions taken to prevent a re-occurrence was to be completed as part of the post fall evaluation. Staff and clinical documentation confirmed that the post fall evaluations did not include actions taken to prevent a re-occurrence following resident #103's five falls in 2015.

c) Staff did not comply with the directions contained in the "Skin Care and Wound Care Program", identified as CN-F-05-1 and dated June 2010.

The policy directed residents identified with altered skin integrity will have the wound assessed with every dressing change (minimum of weekly) to detail the progress of the wound including a narrative update. The DOC confirmed that weekly wound assessments had not been completed for resident #103 when the resident sustained an alteration in their skin in 2015. (Inspector #129) [s. 8. (1) (b)]

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 plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishing and equipment were kept clean and sanitary and that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

a) During the initial tour of the home on April 30, 2015, it was observed in the Clifton and Elgin Bathing areas that there were a number of chipped and broken tiles on the walls. Wall patching was evident in the "Elgin Chrysler" room; however, the damaged area had not been repainted. Flooring located outside of "Elgin Chrysler" room was observed to be torn at the corner and wall damage was observed in two identified resident rooms, without evidence of repair. The Manager of Maintenance confirmed he was not aware of the areas identified as requiring repair. (Inspector #130)

b) On May 4, 2015, the carpet in the common lounge on second floor was observed to have a significant amount of debris. The area was observed again on May 5, 2015 and noted to be in the same state of cleanliness. The Manager of Housekeeping observed the area and confirmed that the area was unacceptable and in need of vacuuming. (Inspector #130) [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

a) During a tour of the home on May 1, 2015, tub lift seat surfaces in the Chippawa and Montrose bathing rooms were observed to have the surface layers exposed and worn and no longer in a state or condition to allow for adequate cleaning and removal of bacteria. Interviews with the ADOC and the Maintenance Handy-man confirmed that they were not aware of the condition of the tub lift seats and the ADOC who is also in

charge of the home's Infection Prevention and Control Program, confirmed that the seat surfaces were worn to a degree that would not ensure adequate cleaning. An interview with the Administrator and the Maintenance Handy-man confirmed that the tub lifts were not part of the home's preventative maintenance program. The Administrator confirmed that while the lifts were part of a preventative maintenance program completed by an external contractor on a yearly basis, more frequent internal monitoring was not in place. (Inspector #214)

b) During a tour of the home on April 30, 2015, tub lift seat surface in the Elgin bathing room was observed to have the surface layer exposed and worn and no longer in a state or condition to allow for adequate cleaning and removal of bacteria. Interviews with the ADOC and the Maintenance Handy-man confirmed that they were not aware of the condition of the tub lift seats and the ADOC who was also in charge of the home's Infection Prevention and Control Program, confirmed that the seat surface was worn to a degree that would not ensure adequate cleaning. An interview with the Administrator and the Maintenance Handy-man confirmed that the tub lifts were not part of the home's preventative maintenance program. The Administrator confirmed that while the lifts were part of a preventative maintenance program completed by an external contractor on a yearly basis, more frequent internal monitoring was not in place. (Inspector #130) [s. 15. (2) (c)]

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 home, furnishing and equipment are kept clean and sanitary and that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's drugs and treatments.

a) On two identified dates in 2015, resident #102 was observed to an alteration in skin to an identified area. A review of the resident's current Three Month Review medication record, indicated that the resident was prescribed a medication that can increase the risks of bruising and bleeding. A review of the resident's written plan of care, dated in 2015, did not identify this medication or any safety risks associated with taking this medication. An interview with registered staff confirmed that the resident was currently taking this medication and that they were not aware that the alteration in skin was present. The registered staff also confirmed that the resident has had skin alterations of this nature in the past and that no interdisciplinary assessment had been completed regarding the safety risks associated with this medication. (Inspector #214)

b) A critical incident system (CIS) submitted by the home on an identified date in 2015, indicated that resident #310 had sustained an injury to a specified area. An interview with the resident indicated that the injury occurred accidentley when the resident was being assisted with their shower. The resident indicated that they take medication that causes them to injure their skin easily. A review of the resident's Medication Administration Record (MAR) during the same time period in 2015, indicated that the resident was prescribed a medication that can increase the risks of bruising and bleeding. A review of the resident's plan of care did not identify this medication or any safety risks associated with taking this medication. An interview with the ADOC confirmed that the resident was currently taking this medication and that no interdisciplinary assessment had been completed regarding this drug and any safety risks associated. (Inspector #214)

c) According to resident #105's clinical record they were sent to hospital on a specified date in 2014 for unexplained symptoms. The resident returned to the home on a specified date in 2014 with an identified diagnosis and orders to monitor for increased symptoms. It was noted from a specified date in 2014 to a specified date in 2015, the resident had episodes of these symptoms and was noted to be receiving the identified medication routinely. Registered staff confirmed there was no written plan put in place to monitor the resident for increased symptoms while receiving this medication. (Inspector #130) [s. 26. (3) 17.]

2. The licensee failed to ensure that the plan of care was based on, at a minimum interdisciplinary assessment of the special treatments and interventions.

a) Resident #107 was observed in stage one of the Resident Quality Inspection (RQI) sitting in a broda chair with a safety device in place. During stage two of the RQI resident #107 was again observed with the device applied.

A review of the resident's current clinical record indicated that the safety device was a Personal Assistance Services Device (PASD) that was being used for positioning due to the resident's health condition.

Further review indicated that the device had been assessed and documented in the clinical records as a restraint from an identified date in 2012, up to an identified date in 2014. An interview with the Assistant Director of Care (ADOC), indicated that on an identified date in 2015, staff changed the documentation in the clinical record to indicate that the device was a PASD, not a restraint as it did not meet the definition of a restraint.

The resident's restraint plan of care was resolved at that time in 2015, and the PASD plan of care was initiated. During a review of the assessments, it was identified that an assessment had not been completed from an identified date in 2014, to an identified date in 2015, for the safety device.

The ADOC confirmed during an interview that an assessment had not been conducted prior to changing the plan of care for the device from a restraint to a PASD.

It was confirmed by the ADOC that the plan of care was not based on, at a minimum an interdisciplinary assessment of the special treatments and interventions with respect to resident #107. (Inspector #508)

b) Resident #104 was observed in stage one with a safety device in place. A review of the resident's clinical record indicated that resident #104 had a safety device prior to using the observed safety device due to risk for falls.

On an identified date 2015, the resident's original safety device had been discontinued and the observed safety device had been implemented. A review of the resident's clinical records indicated that the resident had a restraint assessment on an identified date 2015, for the original safety device and another assessment for the new safety device on another identified date in 2015.

At the time of the discontinuation of the original safety device and the implementation of the new safety device, there was no Restraint/PASD and Alternative Assessment conducted for resident #104.

It was confirmed by the ADOC that there had been no assessment conducted on an identified date in 2015, when the original safety device was discontinued and the new safety device was implemented. (Inspector #508) [s. 26. (3) 18.]

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 plan of care is based on an interdisciplinary assessment of the resident's drugs and treatments, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 failed to ensure that a written record relating to each evaluation under paragraph 3 included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

a) A review of resident #600's plan of care identified they had an incident on an identified date in 2014 which required medical intervention and brief transfer to hospital. Resident #600 was referred to the Registered Dietitian (RD) on a later date in 2014 for a swallowing assessment. The first RD assessment after the incident was documented on

an identified date in 2014 at which time resident #600 was noted to have required a diet change and an assistance change from able to feed them self to total feeding. In an interview with the Food Service and Nutrition Manager it was identified that the RD assessed resident #600 on an earlier date in 2014. Documentation in the "Millenium Trail Dietitian Visit Record" identified the RD observed resident #600 during meal service and no new interventions or changes to the diet texture were required at that time. In an interview with the RD it was confirmed that resident #600's reassessment completed on an identified date in 2014 was not documented in the plan of care. (Inspector #583) [s. 30. (1) 4.]

2. The licensee failed 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 were documented.

a) Documents and discussions held with the DOC confirmed that the 2014 program review of the Falls Prevention and Management Program did not include the names of the people who participated in the evaluation or the dates the identified changes to the program were implemented. (Inspector #129)

b) On an identified date in 2015, resident #502 grabbed resident #505 on a specific area of their body. A review of resident #505's clinical record indicated that this incident had not been documented. The resident had been examined by staff after this incident occurred to determine if the resident was injured and the resident's were separated to minimize the risk of further incidents. The assessment of resident #505, the interventions and resident #505's response to the interventions were also not documented.

It was confirmed during an interview with the Director of Care, that this incident, including the assessments, the interventions and the resident's responses had not been documented. (Inspector #508)

c) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date in 2014, resident #303 was the recipient of a physical threat by resident #302. The CIS indicated that resident #303 was assessed for any injury or related fears. A review of resident #303's clinical records indicated that no documentation regarding this physical threat or any actions taken had been documented. An interview with the DOC confirmed that not all actions, assessments, interventions or the resident's response to any interventions provided, were documented. (Inspector #214)

d) A review of a Critical Incident System (CIS) that was completed by the home indicated that on an identified date in 2014, resident #302 demonstrated responsive behaviours towards resident #304. A review of resident #304's clinical records indicated that this incident had been documented; however; no documentation regarding any actions taken had been documented. An interview with the DOC confirmed that the resident had been seen by the home's Social Worker following this incident; however; no documentation was completed regarding these actions taken including any assessments, reassessments, interventions and the resident's responses to any interventions. (Inspector #214) [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 a written record relating to each evaluation under paragraph 3 includes the date of the evaluation, the names of the persons who participate in the evaluation, a summary of the changes made and the date that those changes are implemented and 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 #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received annual retraining in accordance with O.Reg.79/10, s. 219(1) 1, as provided for in O. Reg. 79/10, s. 221(1) 1 and 2, in the area of "Falls Prevention and Management" and "Skin and Wound Care", in relation to the following: [76(7) 6]

a) Documents provided by the home and the DOC confirmed that 41 of the 135 staff who provide direct care to residents did not receive training in 2014 in the area of falls prevention and management.
b) Documents provided by the home and the DOC confirmed that 45 of the 135 staff who provide direct care to residents did not receive training in 2014 in the area of skin and wound care. (Inspector #129) [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive annual retraining in accordance with O.Reg.79/10, s. 219(1) 1, as provided for in O. Reg. 79/10, s. 221(1) 1 and 2, in the area of "Falls Prevention and Management" and "Skin and Wound Care", to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized program of housekeeping ensured procedures were implemented for cleaning of common areas in the home that included floors and wall surfaces, in relation to the following: [87(2)(a)(ii)]

a) Procedures were not implemented in the home to ensure that floors and wall surfaces in the Stanford home area were clean. On April 30, 2015 and again on May 14, 2015 it was noted the floor in the resident dining area was soiled with both loose food particles under tables, caked on dark brown material around the perimeter of the room and liquid spills that had dried on the floor. It was also noted that the flooring in the halls, particularly at the doorway to resident's rooms was discoloured and appeared dirty. On May 14, 2015 the housekeeping supervisor confirmed that it appeared as though the area of flooring entering resident's rooms had been waxed without being cleaned first. It was also noted on the above dates that the wall surfaces in the dining room and in the hallways of this home were soiled with soft and dried food particles, dried fluid spills and dirt/scuff marks. On May 14, 2015 the Manager of housekeeping and the supervisor identified the cleaning procedures that had been developed and were unable to explain the condition of the walls floors in this home area based on the cleaning procedures that had been developed. (Inspector #129) [s. 87. (2) (a) (ii)]

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 organized program of housekeeping ensures procedures are implemented for cleaning of common areas in the home that includes floors and wall surfaces, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

a) The Manufacturer's Instructions "Belt Application for Proper Positioning", used by the home for the application of seatbelts indicated: "To be effective, any belt must be: Not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt & pelvic space.)".

On an identified date in 2015 at a specified time, resident #400 was observed with a safety device applied unsafely. The resident was unable to unfasten the device when asked. The resident's plan of care indicated they were at high risk for falls. The ADOC observed the device and confirmed the device was not applied in accordance with the Manufacturer's Instructions. (Inspector #130)

b) Resident #300 was observed on a specified date in 2015, with a safety device applied unsafely. The resident was unable to undo the device when asked. A review of the Manufacturer's Instructions for this physical device indicated that the device was to be applied with just enough space for two fingers to fit between the device and the resident. An interview with registered staff and front line nursing staff confirmed that the device used for this resident was a physical restraint and was not applied according to the Manufacturer's Instructions. (Inspector #214)

c) On an identified date in 2015, resident #108 was observed with a safety device applied. The device was noted to be applied unsafely. The resident was unable to undo the device when asked. A review of the Manufacturer's Instructions indicated the device was to be applied with just enough space for two fingers to fit between the belt and the pelvic crest. An interview with registered staff and front line nursing staff confirmed that the front fastening seat belt device used for this resident was a physical restraint and was not applied in accordance with the Manufacturer's Instructions. (Inspector #214) [s. 110. (1) 1.]

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 following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

a) During a tour of the Chippawa unit bathing room on May 1, 2015, a posted memo was observed that indicated that each resident has their own set of nail clippers for their own personal use. All clippers should be labeled with resident name (or initials) and located in the drawers labeled for the resident. A review of these drawers indicated that 11 out of 33 individual resident nail clipper drawers had no nail clippers in the drawers. An interview with the ADOC who is also in charge of the infection prevention and control program in the home, confirmed that not every resident had their own set of nail clippers for personal use as required.

b) During a tour of the Chippawa unit bathing room on May 1, 2015, it was observed that resident's had individual nail clipper drawers with their room numbers listed on the outside of each drawer. A review of two identified residents' drawers identified nail clipping residue in the bottom of both drawers. An interview with the ADOC, who is also in charge of the Infection Prevention and Control Program in the home, confirmed that nail clipping residue was not to be in the drawers and that the drawers had not been

cleaned as required.

c) During a tour of the Montrose bathing room on May 1, 2015, one roll on and one stick deodorant were observed unlabeled on the cart next to the bathtub. An interview with the ADOC, who is also in charge of the infection prevention and control program in the home, confirmed that all resident personal hygiene products were to be used for individual use only and were to be labeled. (Inspector #214)

d) During a tour of the home on April 30, 2015, the following observations were made:

i) In the the Elgin Bathing area, the under-surface of the tub lift chair was noted to contain a build-up of white residue; unlabeled stick deodorant was stored in a common care basket next to the bath tub and two unlabeled urinals were stored on the grab bar next to the toilet of the adjoining bathroom.
ii) In the Clifton Bathing area, an unlabeled urinal was stored on the grab bar next to the toilet of the adjoining bathroom; a used, unlabeled roll-on deodorant was stored in the cupboard and at least six unlabeled nail clippers were stored in the same cupboard.

e) During a medication observation on May 8, 2015 at 1200 hours in the Montrose Home area, the registered staff was observed to check the capillary blood glucose (CBG) levels of resident #401, by puncturing the skin on their finger with a needle stick and placing the blood drawn onto the blood monitoring strip of the blood monitoring device. It was observed that the staff had not washed their hands before or after the procedure. The registered staff proceeded to perform the same procedure on resident #402. (Inspector #130) [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #106 received fingernail care, including the cutting of fingernails.

a) Resident #106 was observed in stage one during resident observation to have long fingernails. A review of the resident's clinical record indicated that the resident's nails were to be checked and trimmed on bath days and when necessary. A review of the Personal Support Worker (PSW) Flow Sheets over a three week period in 2015 indicated that resident #16 had received a bath on six occasions during this time period.

The PSW flow sheets had indicated that over this period of time the resident had only had their fingernails trimmed once.

It was confirmed by staff that the resident had not received fingernail care, including the cutting of fingernails. (Inspector #508) [s. 35. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff. [50(2)(b)(iv)]

a) Registered staff did not assess resident #103 at least weekly following the resident sustaining an area of skin impairment on an identified date in 2015. Staff and clinical documentation confirmed that the resident was not reassessed at any time prior to an identified date in 2015. (Inspector #129) [s. 50. (2) (b) (iv)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

a) The quarterly MDS completed for resident #108 on an identified date in 2015, indicated that the resident was incontinent of bladder. The quarterly MDS completed for the resident on an identified month in 2014, indicated that the resident was frequently incontinent of bladder. A review of the Bowel and Bladder Assessment that was completed a few month later, identified that the resident did have bladder incontinence; however; the areas on this assessment for onset, duration, symptoms over the past 3 months and types of incontinence, were blank.

The RAI Coordinator confirmed that the resident had a decline in their bladder continence status and did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. (Inspector #214) [s. 51. (2) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #302's clinical record indicated that the resident demonstrated known responsive behaviours.

A) According to the resident's progress notes on a specified date in 2014, documentation indicated that the resident started yelling at a co-resident who was entering the dining room in front of them. Staff documented that they told the resident that they could not yell at any of the residents; however, no documentation was included regarding the resident's response to the intervention provided.

According to the resident's progress notes on another identified date in 2014, documentation indicated that the resident had an argument with two other co-residents over two different issues and that the resident replied to both co-resident's in an aggressive manner and instigated a fight. Staff documented that the other resident was removed from the dining room and staff continued to monitor behaviour; however, no documentation was included regarding what actions were taken to respond to the needs of resident #302 or their response to any interventions that were implemented.

An interview with the DOC confirmed that documentation was not completed regarding actions taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the incident's noted above. (Inspector #214) [s. 53. (4) (c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before discharging a resident under O.Reg.79/10, s.145 (1), the licensee provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

a) A review of a Critical Incident System (CIS) that was submitted by the home indicated that on a specified date in 2014, resident #302 was discharged from the home as the resident's requirements for care had changed and the home could not provide a sufficiently secure environment. An interview with the DOC indicated that the home had not provided written notice to the resident and was unable to locate the written notice provided to the resident's substitute decision-maker, that set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the home's decision to discharge the resident. (Inspector #214) [s. 148. (2)]

Issued on this 6th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_323130_0008
Log No. / Registre no:	H-002381-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 30, 2015
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MILLENNIUM TRAIL MANOR 6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that all resident's including resident #103 (falls and changes in skin integrity), resident #111(changes in urinary incontinence), resident #108 (worsening responsive behaviours) and resident #507 (worsening wandering and exit seeking behaviours) have their plans of care reviewed and revised when the resident's care needs change. The plan is to include, but is not limited to the following:
1. The development and implementation of a process that staff must follow when it has been identified that a resident's care needs have changed.
2. The development and implementation of a process and time-line for ongoing monitoring of compliance, related to the identification of changes in resident's care needs as well as the application of the above noted care pathway/protocol.
The plan is to be submitted on or before August 15, 2015, to Phyllis Hiltz-Bontje via e-mail at Phyllis.Hiltz-Bontje@ontario.ca.

Grounds / Motifs :

1. Previously issued non –compliant [6(10) b] on December 31, 2012 as a VPC and [6(10) c] on August 8, 2014 as a VPC.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following: [6(10)(b)]

a) Resident #103's plan of care was not reviewed and revised when clinical documentation indicated the resident began to fall. Clinical documentation indicated the resident fell five times over a two month period in 2015. Care interventions initiated in 2014 in order to meet the identified goal that the resident would be free of falls, included: the use of one bed rail while in bed, staff were to check the resident every hour for safety, staff were to encourage the resident to use handrails or assistive devices, ensure a clutter free environment and a fall mat beside the bed. The RAI Coordinator confirmed that resident #103's plan of care was not reviewed or revised when the resident began falling and fell five times over a 52 day period of time.

b) Resident #103's plan of care was not reviewed or revised when clinical documentation indicated the resident began demonstrating altered skin integrity. A skin assessment completed on a specified date in 2015, indicated that the resident's family reported an area of skin impairment to a specified area.

Staff and clinical documentation confirmed that the resident sustained an area of skin impairment to a specified area on an identified date in 2015, that required assessment and treatment in hospital as a result of a fall. A registered practical nurse (RPN), providing care to the resident, confirmed that although the resident's plan of care indicated a risk for pressure ulcers, there were no care directions for staff in the management of current skin integrity issues, care to prevent further injuries to the resident's skin or hygiene care in relation to the current areas of altered skin integrity.

c) Resident #111's plan of care was not reviewed and revised when data collected on a RAI-MDS assessment completed on an identified date in 2015, indicated the resident's urinary continence status had deteriorated since the last review and the resident was now frequently incontinent of urine. Staff and clinical documentation confirmed that the goal of care remained that the resident would be continent and there were no changes to the care interventions for this resident.

d) Resident #108's plan of care was not reviewed and revised when data collected on a RAI-MDS assessment completed on an identified date in 2015, indicated the resident's mood and behavioural symptoms had deteriorated over the last 90 days. The data collected indicated that the resident was now demonstrating several different responsive behaviors. The resident was also experiencing changes in their usual sleep pattern and repetitive physical

movements on an almost daily basis. Staff also documented that the resident was demonstrating verbally abusive behaviours almost daily and these behaviours were not easily altered. The associated RAP completed following this data collection did not include any rationale for care planning based on the noted deterioration in the resident's mood and behaviour symptoms.

Staff interviewed confirmed that the resident's plan of care was not reviewed or revised and there were no care directions for staff in the assessment or management of these mood and behaviour changes. (Inspector #129)

e) Resident #507 had been identified as having a specific responsive behaviour. On an identified date in 2014, resident #507 had increased confusion and was demonstrating this responsive behaviour. The following month, the responsive behaviour increased and the resident remained confused. The resident was on medication to treat an infection that may have contributed to an increase in the resident's confusion. The following month in 2014, the resident wandered outside of the building without appropriate clothing for the outside temperatures. The resident was discovered by co-resident and redirected the resident back into the home.

A review of the resident's plan of care indicated that during the time that the resident had increased confusion and these behaviours, the plan of care had not been reviewed and revised until after the identified incident occurred in 2014.

It was confirmed by the RAI Coordinator that the resident's plan of care was not reviewed or revised when the resident's care needs changed. (Inspector #508) [s. 6. (10) (b)] (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident, including residents #201, #202, #400 and #506, as specified in the plan of care, specifically related to nutritional care, responsive behaviours and follow-up of diagnostic imaging reports where required.

Grounds / Motifs :

1. Previously issued March 2013 and March 2014 , as VPC.

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.

a) Resident #506 had responsive behaviours that included verbal and physical aggression towards co-residents. On an identified date in 2014, resident #506 was witnessed touching a co-resident in an inappropriate manner. One to one staffing was implemented to minimize the risk of further incidents of responsive behaviours towards co-residents. Two days later, resident #506 pushed a co-resident when the co-resident was standing close to them. The staff member responsible for monitoring resident #506 had left the unit for a break and during this time resident #506 was not being monitored and no staff intervened to prevent this occurrence.

It was confirmed by the DOC that care set out in the plan of care was not provided to resident #506 as specified in the plan. (Inspector #508)

b) Resident #400 sustained an injury from a fall on a specified date in 2014. The resident complained of pain to specific areas post fall for which x-rays were ordered by the Physician. A Diagnostic Imaging Report dated dated after the fall

in 2014 indicated there were no new fractures; however, the report indicated "if symptoms persist, a follow up is recommended to assess for an occult fracture". This information was communicated in the plan of care. Progress notes and pain assessments completed over a three month period in 2014 indicated the resident continued to demonstrate increased pain and required increased analgesics. Follow-up x-rays were not obtained until a later date in 2014, which showed a fracture to a specific area. The ADOC reviewed the record and confirmed that care was not provided to the resident as specified in the plan. (Inspector #130)

c) Resident #201 did not receive care as specified in the plan of care when it was noted that the resident was provided pureed bread at the noon meal on an observed day in 2015. The PSW providing the resident with assistance at this meal indicated to the Inspector that they were aware the resident was not to have bread. The dietary serving staff indicated that the resident could have the bread because sometimes the resident's spouse allowed the resident to have bread. The dietary serving staff confirmed that the dietary kardex directed that the resident was not to be given bread and dietary directions in the resident's plan of care directed that the resident was not to have bread at the family's request.

d) Resident #202 was observed during the noon meal on an identified date in 2015 to take a co-resident's glass of milk. The PSWs assisting in the dining room were provided with this information and provided the co-resident with another glass of milk, but did not remove the glass of milk taken by resident #202. Resident #202 drank the glass of milk belonging to the other resident. It was verified by staff that the milk taken by resident #202 was regular milk. The dietary server confirmed that resident #202 was not to have regular milk as specified in the plan. (Inspector #129) [s. 6. (7)]
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office /
Bureau régional de services : Hamilton Service Area Office