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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_577611_0002	001329-18	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

KELLY CHUCKRY (611), CATHY FEDIASH (214), LISA BOS (683), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 22, 23, 24, 25, 26, 29, 30, 31, 2018.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, observed medication administration, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes.

Eight (8) Critical Incident inspections, five (5) complaint inspections and four (4) inquiries were conducted concurrently with this Resident Quality Inspection.

The eight (8) Critical Incident inspections included Log #033835-16, Log #008565-17, Log #011421-17, and Log #023749-17 all pertaining to falls prevention, Log #034468-16 pertaining to medication management, Log #002706-17 pertaining to responsive behaviours, Log #007326-17 pertaining to personal support services and nutrition hydration, and Log #021957-17 pertaining to personal support services. The five (5) complaint inspections included Log #000700-17 and Log # 023163-17 both pertaining to personal support services, Log # 001027-17 pertaining to responsive behaviours, Log #008088-17 pertaining to personal support services and nutrition hydration, and Log #024677-17 pertaining to skin and wound and personal support services. The four (4) inquiries included Log #027533-17, Log #027736-17, and Log #027538-17 all pertaining to falls prevention, and Log # 027037 -17 pertaining to the prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, the Medical Director, Nurse Practitioner, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Therapeutic Recreation Services, Physiotherapist (PT), Food Service and Nutrition Manager, Resident Assessment Instrument (RAI) Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aids, and housekeeping aides.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **6 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was free from neglect by the licensee or staff in the home.

An incident occurred with resident #006 on an identified date. As a result of this incident, resident #006 was exhibiting signs of pain and it was further confirmed that this resident sustained an injury.

A review of the resident's clinical record during a two week period of time indicated that the resident's pain had not been managed. During the identified period of time, it was documented that resident #006 was experiencing varying degrees of unmanaged pain a total of 15 times. During this time, interventions were not utilized. In some instances pain was identified during the provision of care.

An identified intervention was prescribed prior to the provision of care for resident #006, however was not fully implemented to help manage their pain.

For the purposes of the Act and this Regulation, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During interviews with registered staff #102, registered staff #104, PSW staff #150 and staff #140, it was confirmed that the resident was witnessed to be in extreme amounts of pain over the duration of this period and actions were not taken by staff to ensure that the resident received effective pain control.

It was confirmed through record review, interviews with staff and the DOC that the licensee failed to ensure that resident #006 was free from neglect by the licensee or staff in the home.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #011421-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On an identified date, it was confirmed that resident #005 sustained an injury. This resident had an intervention in place, as a result of the injury.

On a subsequent identified date, resident #005 had an area of altered skin integrity. Documentation and an interview with registered staff #104 indicated that on an identified date, an assessment of the intervention was conducted, including a review of this resident's skin integrity. The intervention was discontinued for this resident.

A review of the resident's plan of care during a 17 day period of time, indicated that no plan of care had been in place to monitor and assess for any potential complications related to altered skin integrity and the identified intervention.

An interview with the DOC and ADOC confirmed that a written plan of care for resident

#005 that set out the planned care for the resident in relation to the above, had not been in place.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection #024677-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

An incident occurred with resident #006 on an identified date. As a result of this incident, resident #006 was exhibiting signs of pain and it was further confirmed that this resident sustained an injury.

A review of the resident's clinical record during a two (2) week period of time indicated that the resident's pain had not been managed, despite interventions being in place. It was identified that during this period of time, the resident experienced extreme pain during the provision of care.

During a review of the physician's order form, it was identified that on an identified date, an intervention was ordered to assist with the management of pain prior to the provision of care. The resident continued to experience pain. The resident's intervention was reassessed and changes were made to better manage the resident's pain. These interventions were not implemented for resident, as directions were not transcribed on the MAR.

It was confirmed during an interview with registered staff #104 and the RAI Co-ordinator that the plan of care for resident #006 did not set out clear directions to staff and others who provided direct care to the resident.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #011421-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 6. (1) (c)]

3. 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 Critical Incident System (CIS) submitted by the home, indicated that on an identified

date, an incident occurred with resident #005 during the provision of care. After the incident, it was confirmed that an injury occurred as a result of the incident.

A review of the home's investigative notes and interviews with PSW staff #149 and #212 indicated that following morning care on the identified date, resident #005 was being provided assistance with the provision of resident care as it related to transferring.

A review of the resident's written plan of care in place at the time of the incident was conducted. The RAI Coordinator, confirmed that a specific intervention was to be in place for this resident during morning transfers.

A review of the resident's clinical record indicated that no assessment in relation to the resident's intervention during morning transfers was able to be found. The RAI Coordinator confirmed that no assessment had been completed and that the care set out in the plan of care had not been based on an assessment of the resident and the needs and preferences of the resident in relation to their transfer status.

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 where there is a written plan of care for each resident that sets our the planned care for the resident, to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, and to ensure that 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 #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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was complied with, in accordance with r.114(1), that required a long term care home to ensure that there was an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents.

A) The home's "Medication Procedures, Control of Narcotics and Controlled Drugs" policy revised (September, 2013), CN-M-11-7, indicated that when an as needed (PRN) medication is given, staff must document on the PRN sheet why the medication was given and what effect it had.

A review of the PRN Medications/Treatment Notes for resident #006 indicated that staff did not comply with the home's policy when the effectiveness of the PRN medications were not consistently documented. Review of the PRN medications administered during a 13 day period, indicated that on five (5) occasions, the effectiveness of these medications had not been documented as directed in the home's policy.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #011421-17, conducted concurrently during the Resident Quality Inspection (RQI).

B) The home's "Doctor's Orders" policy (revised March, 2011), CN-D-22-1, indicated that all doctor's orders will be transcribed by registered staff. Every order including phone orders will be double checked and double noted after being transcribed. All orders are to be processed promptly.

A review of the Physician's Order Form for resident #005 and a Medication Incident Report, indicated that the physician made medication changes on an identified date in December 2017. A new drug had been ordered and another drug was discontinued.

According to the Medication Incident Report and review of the resident's December MAR, the order had been processed, the resident was receiving the new drug; however, the order had not been double checked until seven (7) days later, and had not been transcribed onto the MAR until ten days after the physician had made the changes. [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 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 is in compliance with and is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS submitted by the home, indicated that on a specified date, resident #005 was transferred by two staff following morning care. During the transfer, an incident occurred and it was confirmed that an injury occurred as a result of the incident.

A review of the home's investigative notes and interviews with PSW staff #149 and #212 indicated that following morning care on the identified date, resident #005 was being provided assistance with the transfer. A review of the resident's written plan of care in place at the time of the incident was conducted. The RAI Coordinator, confirmed that a specific intervention was to be in place for this resident during morning transfers.

A review of the resident's written plan of care in place at the time of the incident and confirmed by the RAI Coordinator, indicated that an intervention was not in place for morning transfers.

An interview with the DOC confirmed that staff had not used safe transferring and positioning techniques.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection #023749-17 and a complaint inspection #023163-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 36.]

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 staff use safe tranferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

On an identified date, an area of altered skin integrity was noted for resident #005.

A review of the resident's clinical record for a three (3) month period of time in 2017, indicated that weekly reassessments of the resident's altered skin integrity had not been completed on two occasions, A review of the weekly wound assessment completed after the three (3) month period of time, indicated that the area of altered skin integrity had gotten worse.

An interview with the DOC and ADOC confirmed that weekly reassessment of the resident's altered skin integrity had not been consistently completed.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection #024677-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 50. (2) (b) (iv)]

2. The licensee failed to ensure that when a resident was exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, that they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On January 26, 2018, a review of resident #007's plan of care was conducted. During this review it was determined that this resident had a total of four (4) areas of altered skin integrity. For a three (3) month period of time, one area of altered skin integrity did not have a weekly skin assessment completed a total of eight (8) times.

For an identified one (1) month period of time, an area of altered skin integrity did not have a weekly skin assessment completed a total of three (3) times.

The third area of altered skin integrity for resident #007 was identified on a specific date. A weekly skin assessment had not been completed for this area of altered skin integrity for 11 days.

The fourth area of altered skin integrity was a new wound identified an a specified date. A weekly skin assessment has not been completed for this area of altered skin integrity.

A review of the clinical records was conducted with the Assistant Director of Care (ADOC). It was confirmed that weekly skin assessments were not consistently completed for resident #007 for their identified areas of altered skin integrity.

In a subsequent interview conducted with the Director of Care, (DOC), it was further confirmed that the weekly assessments were not completed. [s. 50. (2) (b) (iv)]

3. The licensee failed to ensure that when a resident was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, that they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On January 29, 2018, a review of resident #008's plan of care was conducted. During this review, it was determined that this resident had an area of altered skin integrity. For an identified 16 week period of time, this pressure ulcer did not have a weekly skin assessment completed a total of nine (9) times.

A review of the clinical records was conducted with the ADOC. It was confirmed that

weekly skin assessments were not consistently completed for resident #008 for their area of altered skin integrity. In a subsequent interview conducted with the DOC it was confirmed that the weekly skin assessments were not completed. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that when a resident was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, that they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On January 29, 2018, a review of resident #018's plan of care was conducted. During this review, it was determined that this resident had a total of two (2) areas of altered skin integrity.

For an identified 16 week period of time, one area of altered skin integrity did not receive a weekly skin assessment a total of seven (7) times. For the same time period, the second area of altered skin integrity did not receive a weekly skin assessment a total of eight (8) times.

A review of the clinical records was conducted with the ADOC. It was confirmed that weekly skin assessments were not consistently completed for resident #008 for their areas of altered skin integrity. In a subsequent interview conducted with the DOC it was confirmed that the weekly skin assessments were not completed. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date, an incident occurred with resident #006, resulting in injury, and subsequent pain for the resident.

During review of the resident's clinical record, it was identified that during a two (2) week period of time, the resident experienced extreme pain during the provision of care.

During a review of the physician's order form, on an identified date, a medication was ordered to be administered prior to the provision of care. On a subsequent date, the medication was reassessed, and changes were made, however the medication was still to be administered prior to the provision of resident care.

These directions were not implemented, and the resident was not consistently receiving the medication prior to the provision of care.

It was confirmed during an interview with registered staff #104 that the order was not transcribed as directed by the physician.

During record review with the DOC it was confirmed that the licensee failed to ensure that drugs were administered to resident #006 in accordance with the directions for use specified by the prescriber.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #011421-17, conducted concurrently during the Resident Quality Inspection (RQI). [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 for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During a review of the home's Medication Incident Reports for 2017, it was identified that on an identified date, two (2) residents had incident reports submitted for medication errors.

The Assistant Director of Care (ADOC) followed up with the identified staff member and education was provided as follow up; however, these incidents were not reported to the resident's SDM, the Medical Director, the prescriber of the drug, or the pharmacy provider.

In an interview with the ADOC on January 28, 2018, the ADOC acknowledged that the home does not consistently report medication incidents to the resident's SDM, the Medical Director, the prescriber of the drug, or the pharmacy provider. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

Issued on this 20th day of February, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611), CATHY FEDIASH (214), LISA BOS (683), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2018_577611_0002
Log No. / No de registre :	001329-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 13, 2018
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 :	Lori Turcotte

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from neglect, specifically pertaining to managing residents with pain.

The plan shall include but not be limited to the following:

a) Mandatory education to all relevant staff in pain management, palliative care and end of life care, including the home's policies and current best practice guidelines for managing pain.

b) An interdisciplinary review of residents currently in the home with a plan of care that includes a focus of pain to evaluate the effectiveness of the interventions in place.

Please submit your plan to HamiltonSAO.moh@ontario.ca on or before March 9, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that resident #006 was free from neglect by the licensee or staff in the home.

This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is isolated (1), the severity of the non-compliance has actual harm (3) and the history of non-compliance under Long-Term Care Homes Act, 2007, s. 19(1) is (2) where one or more unrelated non-compliance has been issued in the last

three years.

An incident occurred with resident #006 on an identified date. As a result of this incident, resident #006 was exhibiting signs of pain and it was further confirmed that this resident sustained an injury.

A review of the resident's clinical record during a two week period of time indicated that the resident's pain had not been managed. During the identified period of time, it was documented that resident #006 was experiencing varying degrees of unmanaged pain a total of 15 times. During this time, interventions were not utilized. In some instances pain was identified during the provision of care.

An identified intervention was prescribed prior to the provision of care for resident #006, however was not fully implemented to help manage their pain.

For the purposes of the Act and this Regulation, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During interviews with registered staff #102, registered staff #104, PSW staff #150 and staff #140, it was confirmed that the resident was witnessed to be in extreme amounts of pain over the duration of this period and actions were not taken by staff to ensure that the resident received effective pain control.

It was confirmed through record review, interviews with staff and the DOC that the licensee failed to ensure that resident #006 was free from neglect by the licensee or staff in the home.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #011421-17, conducted concurrently during the Resident Quality Inspection (RQI). [s. 19. (1)] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

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