Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 19, 2020	2020_575214_0005	019578-19, 019836-19, 020532-19, 021974-19, 022430-19, 023883-19, 000690-20	Critical Incident System

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

CATHY FEDIASH (214), GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 4, 5, 6, 7, 11, 12, 2020.

The following intakes were completed during this Critical Incident System (CIS) inspection:

019578-19- related to prevention of abuse and neglect; responsive behaviours.

019836-19- related to falls prevention.

020532-19- related to falls prevention.

021974-19- related to prevention of abuse and neglect; responsive behaviours.

022430-19- related to falls prevention.

023883-19- related to falls prevention.

000690-20- related to prevention of abuse and neglect; responsive behaviours.

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) Facilitator; Nursing Operations Assistant; Nurse Practitioner (NP); Registered Nurses (RN's); Registered Practical Nurses (RPN's); Personal Support Workers (PSW's); residents and families.

During the course of the inspection, the inspector(s) reviewed CIS reports; resident clinical records; relevant policy and procedures; staff training records; program evaluations; and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that resident #003's substitute decision-maker was given an opportunity to participate fully in the development and implementation of their plan of care.

A review of CIS # 2948-000030-19, indicated that on an identified date, resident #003 sustained a fall; was transferred to an identified location and diagnosed with a specified injury.

A review of the CIS and the resident's clinical record indicated the resident had been assessed for an identified fall risk level.

A review of a specified progress note, dated 15 days prior to this incident, indicated an identified person had requested for the resident to have a specified diagnostic test due to their history of falls. The progress note indicated that staff would highlight a note for the Nurse Practitioner (NP) to assess when in next.

A progress note dated the following day, indicated the resident was demonstrating specified actions and symptoms.

A progress note dated three days later, indicated that an identified person had inquired regarding the results of a specified diagnostic test, previously requested. Documentation indicated that no diagnostic test had been ordered and that staff would speak with the NP the following day.

A progress note, with a specified title and dated later the same day, indicated that an identified person had requested a diagnostic test for the resident, related to their fall history. Documentation indicated for the NP to please assess.

A review of the clinical record indicated no further documentation or diagnostic results had been identified that the specified test had been ordered and or conducted.

A progress note dated on an identified date, indicated the resident had returned from an identified location, with a specified diagnosis and treatment, which the home implemented.

During a discussion with the NP, they indicated that the staff in the home had documented a request for an identified diagnostic test in the progress notes, under a specified title. The NP indicated that at the start of their shift, they print and review all progress notes with this title, and they had not followed up in regards to this request and the diagnostic test was not ordered.

Resident #003's substitute decision-maker had not been given an opportunity to participate fully in the implementation of their plan of care. [s. 6. (5)]

2. The licensee has failed to ensure that resident #004 was reassessed for the use of a specified device and the plan of care reviewed and revised when their care needs changed.

A review of CIS # 000031-19, indicated that on an identified date, resident #004, sustained a fall; was transferred to an identified location and diagnosed with a specified injury. In the CIS, under immediate actions taken to prevent reoccurrence, it was indicated that specified devices would be applied for the resident's safety.

A review of a progress note, dated on an identified date, indicated that the devices identified in the CIS, were implemented, with exception of one.

A progress note dated the following day, indicated the resident was attempting to get up

from an identified location and that staff redirected them multiple times.

A progress note dated two day later, indicated that staff were alerted by another resident that resident #004, had fallen from an identified location and sustained an identified injury.

A review of the electronic care plan document indicated the device that had not been implemented as identified in the CI, had been implemented the day after the resident's second fall.

During an interview with the DOC, they indicated that the plan of care for resident #004 had not been reviewed and revised to include all identified interventions, when their care needs changed. [s. 6. (10) (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 resident #003's substitute decision-maker is given an opportunity to participate fully in the development and implementation of their plan of care, to be implemented voluntarily.

WN #2: 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 #005 was protected from abuse by resident #001.

O. Reg. 79/10, s. 2 (1) defines physical abuse as the use of force by a resident that causes physical injury to another resident.

The plan of care for resident #001 indicated the resident had identified diagnoses and responsive behaviours.

The home submitted CIS #2948-000032-19 which described an incident whereby on a specified date, resident #001 demonstrated an identified responsive behaviour toward resident #005, which resulted in an injury to resident #005.

Interviews with staff and information recorded in the clinical record confirmed that resident #005 was not protected from abuse by resident #001. [s. 19. (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 resident #005 is protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used identified devices for resident #003, in accordance with manufacturers' instructions.

A review of CIS #2948-000030-19, indicated that on a specified date, resident #003 sustained a fall; was transferred to an identified location and diagnosed with a specified injury.

Review of a progress note dated the same day, indicated that the resident had an identified device in place at the time of this fall. Staff that were present, tested this device and identified it had not functioned as intended. Staff inspected the device and identified it had not been used in accordance with manufacturer's specifications. Staff set the device up as identified in the manufacturer's specifications and documentation indicated that the device functioned as intended.

Progress notes dated four days following this incident, indicated that specified persons requested to stop using the identified device and replace with a different identified device.

An observation by the Long Term Care Homes (LTCH) Inspector, indicated that the new device had been put into place. The Inspector activated the device in place and observed it had not functioned as intended. The Inspector along with PSW staff #107 and #108 activated the device together. The device again had not functioned as intended. Staff #107 indicated that when activated, specified functions were to occur, and had not. Staff #108 reset the device as identified in the manufacturer's instructions and the device was observed to function as intended. Staff #108 indicated that the device had not been set up as identified in the manufacturer's instructions.

A review of the manufacturer's instructions for the specified devices identified in writing and picture diagram, the required set up for the device.

During an interview with the DOC, they indicated they were aware that the device in place at the time of the resident's fall, had not been set up as identified in the manufacturer's instructions. The DOC confirmed that the device currently in use for the resident, was now set up as per the manufacturer's instructions. [s. 23.]

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 all equipment, supplies, devices, assistive aids and positioning aids for resident #003, in accordance with manufacturer's instructions, to be implemented voluntarily.

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.