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
Oct 13, 2020	2020_569508_0014	016569-20, 017078-20	Complaint

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

Millennium Trail Manor
6861 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 8, 9, 10, 14, 15, 17, 18, 22, 23, 24, 2020.

The following intakes were completed during this complaint inspection:
-Log #016569-20 related to resident to resident abuse;
-Log #017078-20 related to infection prevention and control, neglect, skin and wound and an unsafe transfer;

Please note: This complaint inspection was conducted concurrently during a Critical Incident System inspection #2020_569508_0015.

During the course of the inspection, the inspectors toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures, internal investigative notes, the home's staffing plan, Behavioural Support of Ontario (BSO) referral log and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOCs), the Resident Assessment Instrument (RAI) Coordinator, Clinical Coordinator for Continence, Nursing Operational Assistant, registered staff, Personal Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

- **2 WN(s)**
- **2 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002 was reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Resident #002 had known responsive behaviours upon admission to the home. The Behavioural Support of Ontario (BSO) staff were working with this resident; however, the resident was discharged from their care several months later.

Resident #002 continued to exhibit responsive behaviours towards staff and co-residents with multiple incidents.

Resident #002 wandered into resident #001's room, staff had to intervene to remove resident #002.

A Critical Incident System (CIS) report indicated that resident #002 again wandered into resident #001's room, an altercation occurred which resulted in an injury to resident #001.

The report also indicated that the long-term action plan to correct the situation and prevent recurrence was to refer resident #002 to the BSO.

ADOC #102 acknowledged that there was no referral completed to BSO for resident #002. Clinical records indicated that the current interventions had not been effective.

Sources: resident #002's clinical records, interview with ADOC #102 and other staff. [s. 6. (11) (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 #002 is reassessed and the plan of care is revised because care set out in the plan related to their responsive behaviours is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents or staff who were at risk of harm or were harmed by resident #002 as a result of the resident's responsive behaviours.

Resident #002 had known responsive behaviours upon admission to the home. The Behavioural Support of Ontario (BSO) staff were working with this resident; however, the resident was discharged from their care several months later.

Resident #002 continued to exhibit responsive behaviours towards staff and co-residents with multiple incidents.

Resident #002 wandered into resident #001's room, staff had to intervene to remove resident #002.

A Critical Incident System (CIS) report indicated that resident #002 again wandered into resident #001's room, an altercation occurred which resulted in an injury to resident #001.

The CIS report also indicated that the long-term action plan to correct the situation and prevent recurrence was to refer resident #002 to the BSO; however this was not done. PSWs #127 and #128 confirmed that resident #002 continues to have unpredictable responsive behaviours. ADOC #102 acknowledged that the BSO referral had not been done which potentially resulted in harm to resident #001.

Sources: CIS report, resident #002's clinical record, interviews with PSW #127 and #128 and other staff. [s. 55. (a)]

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 procedures and interventions are developed and implemented for resident #002 to assist residents and staff who are at risk of harm or who are harmed as a result of resident #002's behaviours, to be implemented voluntarily.

Issued on this 26th day of October, 2020

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

Original report signed by the inspector.