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
Nov 17, 2020	2020_569508_0016	020279-20	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)

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): October 16, 19, 20, 21, 23, 2020 (on-site), October 22, 26, 27, 28, 29, 30, 2020 (off-site).

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, the home's death registry, staffing schedules, Public Health reports, and attended daily outbreak meetings with the home's management team and Public Health representatives.

- Log #020279-20, related to unexpected/suspicious deaths, Infection Prevention and Control (IPAC) concerns, management of residents with responsive behaviours, staffing shortages and records management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nursing Operations Assistant, Public Health Inspector, Nursing Scheduling Clerk, registered staff, Personal Support Workers (PSW), housekeeping staff and residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as possible in the circumstances of the unexpected and sudden deaths of residents #001 and #004.

A) Resident #001 was found in their bed with vital signs absent during a routine check by PSW #113.

PSW #113 immediately reported this to Registered Practical Nurse (RPN) #105 who assessed the resident and confirmed that the resident was deceased.

The PSW and RPN indicated that the resident's death was sudden and they did not expect resident #001's death. The Administrator confirmed that the resident's death should have been reported to the Director; however, it had not been reported until after the Long Term Care Home (LTCH) Inspector identified this during the inspection.

Sources: Interviews with the Administrator and other staff, resident #001's clinical records.

B) PSW #114 reported to RPN #106 that resident #004 had an unexpected incident. .

The RPN went and assessed the resident, called the Registered Nurse (RN) and the registered staff attempted interventions; however, the resident became unresponsive and died. Registered staff confirmed that the resident's death was unexpected. The Administrator confirmed that the resident's death should have been reported to the Director; however, it had not been reported until after the LTCH Inspector identified this during the inspection.

Sources: Interview with the Administrator and other staff, resident #004's clinical records. [s. 107. (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 Director is immediately informed, in as much detail as possible in the circumstances of the unexpected and sudden deaths of residents, to be implemented voluntarily.

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.