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
Dec 20, 2021	2021_575214_0015	006814-21, 007124-21, 010539-21, 011744-21	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), ROSEANNE WESTERN (508)

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): November 5, 8, 9, 10, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, and 26, 2021.

This inspection was conducted concurrently with complaint inspection #2021_575214_0014.

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

006814-21- related to falls prevention and management;

007124-21-related to falls prevention and management;

010539-21-related to falls prevention and management;

011744-21-related to falls prevention and management, pain management, minimizing of restraining.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Resident Assessment Instrument (RAI) Coordinator, Health Informatics Coordinator, an equipment vendor, Infection Prevention and Control (IPAC) lead, screener, housekeeping and laundry supervisor, housekeeping staff, registered dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSWs), and residents.

During the course of the inspection, the inspector(s) reviewed relevant records, including but not limited to clinical health records, Public Health reports, CIS reports, policies and procedures, and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **8 WN(s)**
- **5 VPC(s)**
- **8 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. 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 :

The licensee failed to ensure that a resident was protected from neglect.

Neglect is defined as 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.

The resident was injured due to a fall.

The resident was ordered pain medication to manage their pain. The physician initially ordered a specified pain medication with an identified frequency, to be taken when necessary. The order was increased in strength the following day as the initial strength had not managed their pain.

For approximately the next 14 weeks, the resident demonstrated pain, including during specified activities of daily living (ADL). They demonstrated other symptoms and additional falls.

On one occasion, pain medication had been administered to the maximum allowed by the physician’s order and it was documented that it better managed the resident’s pain, however; no attempts were made to obtain a routine pain administration schedule.

Several documented occasions indicated pain medication had been administered when the resident was in pain and identified not to have been effective. No further interventions had been implemented.

On an identified date, the resident was experiencing pain for several hours with no effect from the pain medication. The maximum dose of pain medication had not been administered and no pain assessments conducted.

On an identified date, the physician was notified, and an order was received for a different medication classification and was administered to the resident. There were no changes to the resident’s pain medication or administration schedule.

The resident was neglected when it was identified and documented the resident's pain medication was ineffective and failed to reassess and recognize that the resident's pain was not being managed for several months.

Failure to reassess the resident's pain medication and provide effective pain management, resulted in harm to the resident as the resident continued to experience

pain.

Sources: resident's e-MAR, progress notes, pain assessments, and an interview with the ADOC. [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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that a post-fall assessment, using a clinically appropriate assessment instrument, specifically designed for falls, was conducted for three residents when they fell and sustained injuries.

a) A resident sustained an unwitnessed fall with injuries.

The resident did not always use a specified assistive device. Their plan of care identified five specified fall interventions had been in place.

A fall assessment was conducted. The assessment provided the assessor the ability to check off pre-established factors that may have contributed to the fall. The assessment had not contained an area for the assessor to document any other factors, other than those listed.

The assessment identified two factors as having contributing to this fall.

The assessment asked the assessor to elaborate in a text box, how these factors may have contributed to the fall and the response provided had not been in relation to the identified factors.

The assessment allowed the assessor to check off five, pre-established fall interventions and an other box that would open to a text box to document interventions other than those pre-established. The current interventions identified in place for this fall indicated none of the above and no further interventions were listed in the other box, despite the resident having had five fall interventions in place prior to this fall. This portion of the assessment only prompted the assessor to identify what was to be in place and not if the actual interventions were in place and effective or ineffective, at the time of the fall.

The assessment prompted the assessor to make sure the care plan was updated to include current falls risk and interventions implemented. A total of six pre-established interventions were listed for the assessor to check off. The assessment had not provided an area for the assessor to include any other interventions to implement, specifically, the factors that had been identified as contributing to this fall with injury.

b) A resident sustained an unwitnessed fall with injuries.

A fall assessment was conducted. The assessment provided the assessor the ability to check off pre-established factors that may have contributed to the fall. The assessment had not contained an area for the assessor to document any other factors, other than those listed.

The assessment identified two factors as having contributing to this fall.

The assessment allowed the assessor to check off five, pre-established fall interventions and an other box that would open to a text box to document interventions other than those pre-established. An intervention had been documented as being in place; however, had not identified if this had been in place at the time of the fall and effective or ineffective.

The assessment prompted the assessor to make sure the care plan was updated to include current falls risk and interventions implemented. A total of six pre-established interventions were listed for the assessor to check off. The assessment had not provided an area for the assessor to include any other interventions to implement, specifically, the

factors that had been identified as contributing to this fall with injury.

c) A resident sustained an unwitnessed fall with injuries.

Their plan of care identified two specified fall interventions had been in place.

A fall assessment had not been conducted.

Documentation following the fall indicated the resident had a specified fall intervention in place at the time of the fall and included fall interventions that were to be implemented; however, no assessment was in place that identified predisposing factors that may have contributed to the fall or elaboration on how they may have contributed; had not identified if all the interventions in place at the time of the fall, were in place and effective or not.

It was confirmed a post fall assessment had not been conducted for this resident's fall.

It was confirmed the fall assessment was not a clinically appropriate assessment instrument, designed specifically for falls as it had not provided the assessor the ability to document contributing factors, other than those listed; had not provided for the assessor to document if current interventions in place at the time of the fall, were in place and if they had been effective or not and had not provided the assessor with an area to document any other interventions, other than six pre-determined options.

It was indicated approximately seven months prior, when the same area of non-compliance was issued, that it was unknown what best practice this fall assessment had been based upon as this assessment was now a second version. The same fall assessment was in place, at the time of this inspection.

There is potential for the risk of harm to occur when the current fall assessment is not clinically appropriate as it limits the assessor in identifying predisposing factors; does not prompt the assessor to identify if current fall interventions in place were in place at the time of the fall and were effective or not. The assessment limited the assessor to choose from a list of six, pre-determined interventions to implement, some of which had no relation to the factors that may have contributed to the above resident's falls.

There is potential for the risk of harm to occur when a clinically appropriate assessment instrument, specifically designed for falls, is not conducted. With no assessment, factors that may have contributed to the fall; identification of current interventions in place

and if in place and effective at the time of the fall, and interventions to consider for implementation for future fall management, are not looked at, and may result in further falls with harm.

Sources: critical incident reports, resident progress notes, care plans, assessments, and interviews with the Administrator, and other staff. [s. 49. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting

the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied resident physical devices, in accordance with manufacturer's instructions.

A memorandum to Long-Term Care Homes Licensees and Staff, titled, "Requirements for Falls Prevention and Management Program and Operation of Equipment", dated March 22, 2016, from Karen Simpson, then Director under the LTCH Act, 2007,identified the requirement for staff to use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

Three residents were observed to have a physical device in place. The device was not applied in accordance with manufacturer's instructions and for one resident, was

observed to have caused harm.

Request for a copy of the manufacturer's instructions for the physical device were unable to be provided as the home was unable to identify the maker of the devices and as a result, did not have the instructions.

Failure to apply a physical device in accordance with manufacturer's instructions puts the resident at risk for significant harm.

Sources: resident care plans, progress notes, assessments, physician orders, Memorandum to Long-Term Care Homes Licensees and Staff, and interviews with PSW staff and other staff. [s. 110. (1) 1.]

2. The licensee failed to ensure that staff only applied a physical device to residents, that had been ordered or approved by a physician or registered nurse in the extended class.

a) A resident was observed to have a physical device in place that caused harm.

The physician had ordered the physical device on an identified date; however, the device had been implemented prior to this date.

b) A resident was observed to have a physical device in place.

A physician's order for the physical device, was unable to be located. The resident's care plan had not identified this device was to be applied.

It was confirmed the resident did not have an order for the physical device and indicated that the application of the device had been transferred into the resident electronic health record in error, and as a result, staff applied the device based on the direction in the health record.

There is a potential for harm when a physical device is applied to a resident without an order by a physician or a registered nurse in the extended class as all members of the interdisciplinary team are not aware and are unable to contribute to ensuring the safety of the resident while using the device.

Sources: resident progress notes, physician orders, and interview with PSW staff and others. [s. 110. (2) 1.]

3. The licensee failed to ensure that a resident was released from their physical device and repositioned at least once every two hours.

A resident was observed to have a physical device in place. The resident had not been released from their physical device and repositioned, at least once every two hours. The resident had sustained harm from the use of this physical device.

Sources: resident plan of care, resident observations, and interview with PSW staff. [s. 110. (2) 4.]

4. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented, and included the person who applied the device and the time of application.

Two residents were observed to have a physical device in place. No documentation was in place regarding the person(s) who applied the device and the time of application.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Documenting actions taken with regard to the use of physical devices for resident’s, ensures the required safety and comfort care needs of the resident have been met.

Sources: resident care plans, progress notes, electronic documentation, and interviews with PSW staff and other staff. [s. 110. (7) 5.]

5. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented and included all assessment, reassessment and monitoring, including the resident’s response.

Two residents were observed to have a physical device in place. No documentation was in place regarding all assessment, reassesment and monitoring of the resident, including the resident's response, while the physical device was in place, every eight hours, and at any other time when necessary.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and had not included these requirements, when they moved from the previous paper documentation that had been in place.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Failure to document all assessments, reassessments and the resident's responses when using physical devices, had the potential to result in not providing care that met the safety and comfort needs of the residents.

Sources: resident care plans, progress notes, electronic documentation, and interviews with Registered staff and other staff. [s. 110. (7) 6.]

6. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented, and included every release of the device and all repositioning, every two hours.

Two residents were observed to have a physical device in place. No documentation was in place regarding every release of the device and all repositioning, every two hours.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Sources: resident care plans, progress notes, electronic documentation , and interviews with PSW staff and other staff. [s. 110. (7) 7.]

7. The licensee failed to ensure that every use of a physical device used by two residents, as identified under section 31 of the Act, was documented, and included the removal of the device, including the time of removal and the post-device care.

Two residents were observed to have a physical device in place. No documentation was in place regarding the removal of the device, including the time of removal and post device care.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Failure to document the removal of the device, time of the removal and post-restraining care, had the potential to result in not providing safe and comfortable care to the resident.

Sources: resident care plans, progress notes, electronic documentation, and interviews with PSW staff and other staff. [s. 110. (7) 8.]

Additional Required Actions:

CO # - 003, 004, 005, 006, 007, 008 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 resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the falls prevention and management policy, was complied with for resident's #010 and #012.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program must, at a minimum, provide for strategies to reduce or mitigate falls.

1. The licensee had a policy related to their falls management program that indicated the falls committee met each quarter for the purpose of providing an interdisciplinary forum to reduce the incident of falls. The committee would review statistics on falls, such as

when, where, and patterns and would make recommendations and provide consultation on strategies for staff, resident and family training and identify improvement to residents in the areas of falls prevention.

Three residents sustained falls that had resulted in injuries.

It was indicated the home had recently begun having the fall committee meetings; however, no meeting minutes were able to be located for the falls the three residents sustained.

2. The licensee's policy related to falls prevention, indicated a specified electronic assessment was to be conducted for each resident minimally, on a quarterly basis.

A resident sustained a fall with injury. The specified assessment had been conducted on an identified date. It was indicated that this assessment had been replaced with another assessment. The new assessment had not been conducted for this resident until five months following the previous assessment.

It was identified that the licensee's policy had not been updated to reflect the implementation of the new assessment.

When an interdisciplinary committee to review resident falls does not take place as per the licensee’s policy, this has the potential for risk of harm or harm to occur as factors that may have contributed, patterns, interventions and their effectiveness, are not reviewed on a timely and consistent basis.

When a specified assessment related to falls is not conducted, this has the potential for risk of harm or harm to occur as a resident’s condition can decline over time, placing them at a greater risk for falling, and possible interventions being delayed for implementation. When the policy is not revised and implemented to include changes to the program, this has the potential for staff not to comply with the licensee's policy, as they may not be aware of the changes.

Sources: the licensee’s Falls Committee policy (#CA-03-02, last revised February 24, 2020), Falls Prevention(policy (#CN-F-05-01, last revised April 5, 2019), resident assessments, and interviews with the DOC and other staff. [s. 8. (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 licensee`s falls prevention and management program policies are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the use of physical devices for a resident, was complied with.

The resident had a physical device in place.

Review of the licensee's policy related to physical devices, indicated any resident who used a physical device, was to have a specified assessment, which included physical devices, completed at least quarterly.

At the time of this inspection, the required assessment had not been conducted for a period of approximately four months.

When reassessment of the risks related to the use of a physical device is not conducted as required, a proactive approach identifying the potential for harm, is missed.

Sources: resident's plan of care, licensee's physical device policy (#CN-R-05, last revised on July 17, 2019), and interview with the DOC. [s. 29. (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 the written policy to minimize restraining of residents, is complied with, to be implemented voluntarily.

WN #6: 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 has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers or wounds was assessed by a registered dietitian who was a member of the staff of the home.

A resident had sustained a fall with injury and as a result, sustained alterations to their skin integrity.

No referral had been sent to the registered dietitian (RD) to advise of their altered skin integrity.

Approximately four months later, the resident was identified to have a different area of altered skin integrity.

The RD confirmed they had not received any referrals for this resident and upon being informed by the inspector, assessed the resident and implemented interventions to their nutritional plan of care.

Failure to refer the resident to the RD when there was an alteration in skin integrity put the resident at risk for further skin breakdown.

Sources: resident progress notes, assessments, and an interview with the RD. [s. 50. (2) (b) (iii)]

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 residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers or wounds is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to ensure they complied with the practice requirements of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) system for a resident, following a fall that resulted in a significant change in their condition.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN), under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument -Minimum Data Set) system.

Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii).

Any significant change in a resident's condition, either decline or improvement, shall be reassessed along with RAPs by the interdisciplinary care team using the MDS Full Assessment by the 14th day following the determination that a significant change in status has occurred.

Criteria for determining a significant change in status is identified in the Resident Assessment Instrument (RAI) MDS 2.0 User's Manual, Canadian Version, February 2012, pages 9, 13, and 14. A "significant change" is defined as a major change in the resident's health status that:

• Is not self-limiting
• Impacts on more than one area of the resident's health status; and
• Required interdisciplinary review and/or revision of the care plan.

The home did not meet the criteria for determining a significant change in the status of the resident and did not use the RAI-MDS tool correctly to produce an accurate

assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii):

A resident sustained a fall with injury.

It was confirmed this incident met the requirements of a significant change in their health status. A RAI-MDS assessment, for a significant change in status assessment had not been conducted.

When the resident is not reassessed as required, the plan of care is not reflected of their current needs and preferences and has the potential for harm to occur to any area(s) that were identified as a significant change in their health status.

Sources: critical incident report, resident progress notes, care plan, RAI-MDS assessments, and interviews with the RAI Coordinator, and other staff. [s. 101. (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 the licensee complies with the practice requirements of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) system, to be implemented voluntarily.

WN #8: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident care plan was based on an interdisciplinary assessment of their health conditions, that included risk of falls and other special needs.

A resident sustained a fall with injury.

A fall intervention had been added to the resident's electronic care plan, approximately five weeks later. It was confirmed no assessment could be located to support the implementation of this fall intervention.

A care plan is based on the assessment of the needs and preferences of a resident. When interventions are implemented, that have not been based on an assessment, there is a potential for risk of not identifying the reason it was implemented, including the risk associated with implementing the intervention, which in turn can present difficulty in determining the effectiveness.

Sources: resident progress notes, assessments, care plan, and interview with the Administrator and other staff. [s. 26. (3) 10.]

Issued on this 24th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2021_575214_0015
Log No. / No de registre :	006814-21, 007124-21, 010539-21, 011744-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 20, 2021
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 :	Cindy Harbridge

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 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 must be compliant with s. 19(1) of the LTCH Act, 2007.

Specifically, the licensee shall prepare, submit and implement a plan to ensure this resident and any other resident who requires pain management is not neglected as it relates to pain management.

The plan must include but is not limited to:

a) An audit of all residents in the home who have been identified as having pain.

b) Ensure the identified resident, including any other residents, are assessed for pain to ensure their pain is being managed.

c) Review when necessary (PRN) medications are administered to determine if pain medication changes are required.

Please submit the written plan for achieving compliance for inspection # 2021_575214_0015 to Cathy Fediash, Long Term Care Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Grounds / Motifs :

1. The licensee failed to ensure that a resident was protected from neglect.

Neglect is defined as 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.

The resident was injured due to a fall.

The resident was ordered pain medication to manage their pain. The physician initially ordered a specified pain medication with an identified frequency, to be taken when necessary. The order was increased in strength the following day as the initial strength had not managed their pain.

For approximately the next 14 weeks, the resident demonstrated pain, including during specified activities of daily living (ADL). They demonstrated other symptoms and additional falls.

On one occasion, pain medication had been administered to the maximum allowed by the physician's order and it was documented that it better managed the resident's pain, however; no attempts were made to obtain a routine pain administration schedule.

Several documented occasions indicated pain medication had been administered when the resident was in pain and identified not to have been effective. No further interventions had been implemented.

On an identified date, the resident was experiencing pain for several hours with no effect from the pain medication. The maximum dose of pain medication had not been administered and no pain assessments conducted.

On an identified date, the physician was notified, and an order was received for a different medication classification and was administered to the resident. There were no changes to the resident's pain medication or administration schedule.

The resident was neglected when it was identified and documented the resident's pain medication was ineffective and failed to reassess and recognize that the resident's pain was not being managed for several months.

Failure to reassess the resident's pain medication and provide effective pain management, resulted in harm to the resident as the resident continued to experience pain.

Sources: resident's e-MAR, progress notes, pain assessments, and an interview with the ADOC. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: The resident had actual harm due to their pain not being managed.

Scope: Was identified as isolated as one out of three residents reviewed, had their pain management needs neglected.

Compliance history: In the last 36 months, the licensee was found to be non-compliant with LTCHA, 2007 s. 19 (1) and two-compliance orders (CO), and one Voluntary Plan of Correction (VPC) were issued to the home. (508)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49(2) of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that when the identified residents, and any other resident has fallen, the resident is assessed and that where the condition or circumstances require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The plan must include but is not limited to:

a) Identifying the best practice document(s) and/or guideline(s), the post-fall assessment will be based on.

b) The person(s) responsible for reviewing and revising the assessment instrument, based on the best practice document.

c) The person(s) responsible for ensuring the licensee's falls prevention and management program reflects the use of the clinically appropriate post-fall assessment.

d) The person(s) responsible for implementing the post- fall assessment through training all staff who are required to complete a post-fall assessment. This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

e) An auditing schedule to ensure that where the condition or circumstances of the resident require, a post-fall assessment is conducted. Auditing shall continue until no further concerns arise with the completion of the assessment. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that a post-fall assessment, using a clinically appropriate assessment instrument, specifically designed for falls, was conducted for three residents when they fell and sustained injuries.

a) A resident sustained an unwitnessed fall with injuries.

The resident did not always use a specified device. Their plan of care identified five specified fall interventions had been in place.

A fall assessment was conducted. The assessment provided the assessor the ability to check off pre-established factors that may have contributed to the fall. The assessment had not contained an area for the assessor to document any other factors, other than those listed.

The assessment identified two factors as having contributing to this fall.

The assessment asked the assessor to elaborate in a text box, how these factors may have contributed to the fall and the response provided had not been in relation to the identified factors.

The assessment allowed the assessor to check off five, pre-established fall interventions and an other box that would open to a text box to document interventions other than those pre-established. The current interventions identified in place for this fall indicated none of the above and no further interventions were listed in the other box, despite the resident having had five fall interventions in place prior to this fall. This portion of the assessment only prompted the assessor to identify what was to be in place and not if the actual interventions were in place and effective or ineffective, at the time of the fall.

The assessment prompted the assessor to make sure the care plan was updated to include current falls risk and interventions implemented. A total of six pre-established interventions were listed for the assessor to check off. The assessment had not provided an area for the assessor to include any other interventions to implement, specifically, the factors that had been identified as contributing to this fall with injury.

b) A resident sustained an unwitnessed fall with injuries.

A fall assessment was conducted. The assessment provided the assessor the ability to check off pre-established factors that may have contributed to the fall. The assessment had not contained an area for the assessor to document any other factors, other than those listed.

The assessment identified two factors as having contributing to this fall.

The assessment allowed the assessor to check off five, pre-established fall interventions and an other box that would open to a text box to document interventions other than those pre-established. An intervention had been documented as being in place; however, had not identified if this had been in place at the time of the fall and effective or ineffective.

The assessment prompted the assessor to make sure the care plan was updated to include current falls risk and interventions implemented. A total of six pre-established interventions were listed for the assessor to check off. The assessment had not provided an area for the assessor to include any other interventions to implement, specifically, the factors that had been identified as contributing to this fall with injury.

c) A resident sustained an unwitnessed fall with injuries.

Their plan of care identified two specified fall interventions had been in place.

A fall assessment had not been conducted.

Documentation following the fall indicated the resident had a specified fall intervention in place at the time of the fall and included fall interventions that were to be implemented; however, no assessment was in place that identified predisposing factors that may have contributed to the fall or elaboration on how they may have contributed; had not identified if all the interventions in place at the time of the fall, were in place and effective or not.

It was confirmed a post fall assessment had not been conducted for this resident's fall.

It was confirmed the fall assessment was not a clinically appropriate assessment instrument, designed specifically for falls as it had not provided the assessor the ability to document contributing factors, other than those listed; had not provided for the assessor to document if current interventions in place at the time of the fall, were in place and if they had been effective or not and had not provided the assessor with an area to document any other interventions, other than six pre-determined options.

It was indicated approximately seven months prior, when the same area of non-compliance was issued, that it was unknown what best practice this fall assessment had been based upon as this assessment was now a second version. The same fall assessment was in place, at the time of this inspection.

There is potential for the risk of harm to occur when the current fall assessment is not clinically appropriate as it limits the assessor in identifying predisposing factors; does not prompt the assessor to identify if current fall interventions in place were in place at the time of the fall and were effective or not. The assessment limited the assessor to choose from a list of six, pre-determined interventions to implement, some of which had no relation to the factors that may have contributed to the above resident's falls.

There is potential for the risk of harm to occur when a clinically appropriate assessment instrument, specifically designed for falls, is not conducted. With no assessment, factors that may have contributed to the fall; identification of current interventions in place and if in place and effective at the time of the fall, and interventions to consider for implementation for future fall management, are not looked at, and may result in further falls with harm.

Sources: critical incident reports, resident progress notes, care plans, assessments, and interviews with the Administrator, and other staff. [s. 49. (2)]

An order was made by taking the following factors into account:

Severity: Three residents sustained falls that resulted in actual harm. The post-fall assessment in place at the time of the residents' falls, limited the assessor to only select from a list of pre-disposed risk factors; had not contained an area to verify if interventions in place at the time of the fall were in place and effective,

and limited the assessor to only select from a list of pre-determined interventions to implement as a result of the incident. There is a potential for risk of secondary falls occurring, with harm, when prior falls are not assessed, and not assessed using a clinically appropriate assessment.

Scope: This non-compliance was widespread as a clinically appropriate post-fall assessment, specifically designed for falls, had not been conducted for three out of three residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 49(2) and one Voluntary Plan of Correction (VPC) was issued to the home. (214)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

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

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

The licensee must be compliant with s. 110 (1) 1 of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that staff apply physical devices for residents who require them, in accordance with any manufacturer's instructions.

The plan must include but is not limited to:

a) The person(s) responsible for ensuring residents who have a physical device have the manufacturer's instructions for their device.

b) If manufacturer's instructions are not available and the device has been implemented, the home must reassess the resident who requires a device and order a replacement with the manufacturer's instructions.

c) The person(s) responsible for ensuring all staff who apply and monitor the physical devices are educated on the manufacturer's instructions. This training shall include where the manufacturer's instructions are located in the LTC home. This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

d) An auditing schedule to ensure that residents who use physical devices, are done so in accordance with the manufacturer's directions. Auditing shall continue until no further concerns arise and resident's physical devices are applied as per manufacturer's instructions.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Grounds / Motifs :

1. The licensee failed to ensure that staff applied resident physical devices, in accordance with manufacturer's instructions.

A memorandum to Long-Term Care Homes Licensees and Staff, titled, "Requirements for Falls Prevention and Management Program and Operation of Equipment", dated March 22, 2016, from Karen Simpson, then Director under

the LTCH Act, 2007,identified the requirement for staff to use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

Three residents were observed to have a physical device in place. The device was not applied in accordance with manufacturer's instructions and for one resident, was observed to have caused harm.

Request for a copy of the manufacturer's instructions for the physical device were unable to be provided as the home was unable to identify the maker of the devices and as a result, did not have the instructions.

Failure to apply a physical device in accordance with manufacturer's instructions puts the resident at risk for significant harm.

Sources: resident care plans, progress notes, assessments, physician orders, Memorandum to Long-Term Care Homes Licensees and Staff, and interviews with PSW staff and other staff. [s. 110. (1) 1.]

An order was made by taking the following factors into account:

Severity: Three residents were observed to have a physical device in place that had not been applied in accordance with manufacturer's instructions, resulting in harm to one resident and the potential for harm to the other two residents.

Scope: This non-compliance was widespread as three out of three residents reviewed, had their physical devices applied in a manner that placed them in harm and at risk of harm, as manufacturers' instructions were not available.

Compliance History: In the last 36 months, the licensee was found to have previous non-compliance, none of which are the same subsection. (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 04, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee must be compliant with s. 110 (2) 1 of O. Reg. 79/10.

Specifically, the licensee must:

a) Identify all residents who have a physical device in place.

b) Ensure that an order or approval for the physical device by a physician or registered nurse in the extended class (RNEC), is obtained.

c) Conduct audits, on a schedule determined by the home, to ensure that physical devices used by residents, have been ordered or approved, as required. Audit records shall be retained.

Grounds / Motifs :

1. The licensee failed to ensure that staff only applied a physical device to residents, that had been ordered or approved by a physician or registered nurse in the extended class.

a) A resident was observed to have a physical device in place that caused harm.

The physician had ordered the physical device on an identified date; however, the device had been implemented prior to this date.

b) A resident was observed to have a physical device in place.

A physician's order for the physical device, was unable to be located. The resident's care plan had not identified this device was to be applied.

It was confirmed the resident did not have an order for the physical device and indicated that the application of the device had been transferred into the resident electronic health record in error, and as a result, staff applied the device based on the direction in the health record.

There is a potential for harm when a physical device is applied to a resident without an order by a physician or a registered nurse in the extended class as all members of the interdisciplinary team are not aware and are unable to

contribute to ensuring the safety of the resident while using the device.

Sources: resident progress notes, physician orders, and interview with PSW staff and others. [s. 110. (2) 1.]

An order was made by taking the following factors into account:

Severity: There was harm to a resident and a risk of harm to another resident when their physical devices had been applied without an order or approval.

Scope: This non-compliance was identified as a pattern as two out of three residents reviewed, had no orders or approval for their physical device.

Compliance History: In the last 36 months, the licensee was found to have previous non-compliance, none of which are the same subsection.
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee must be compliant with s. 110 (7) 5 of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure documentation for the identified residents, and any other resident using physical devices, includes the person who applied the device, time of application and hourly monitoring.

The plan must include but is not limited to:

a) The person(s) responsible for ensuring the resident's plan of care, including electronic documentation systems, contains all requirements to document who applied the device, time of application and hourly monitoring.

b) The person(s) responsible for implementing training to all staff who apply and monitor physical devices, regarding the requirements to document these actions. This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

c) An auditing schedule to ensure that residents who use physical devices, have documentation that includes who applied the device, time of application and hourly monitoring. Auditing shall continue until no further concerns arise with the completion of the required documentation. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented, and included the person who applied the device and the time of application.

Two residents were observed to have a physical device in place. No documentation was in place regarding the person(s) who applied the device and

the time of application.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Documenting actions taken with regard to the use of physical devices for resident's, ensures the required safety and comfort care needs of the resident have been met.

Sources: resident care plans, progress notes, electronic documentation, and interviews with PSW staff and other staff. [s. 110. (7) 5.]

An order was made by taking the following factors into account:

Severity: There was minimal risk to two residents when the actions of who applied their physical device, the time of application, and hourly monitoring, had not been documented.

Scope: This non-compliance was identified as a pattern as two out of three residents reviewed, had no documentation in place, for the required physical device actions, performed by the staff.

Compliance History: In the last 36 months, the licensee was found to have previous non-compliance, none of which are the same subsection.
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 04, 2022

Ontario

Ministry of 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

Ministère 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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

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

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

The licensee must be compliant with s. 110 (7) 6 of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure documentation for the identified residents, and any other resident using physical devices, includes all assessments, reassessments and monitoring, including the resident's response, every eight hours.

The plan must include but is not limited to:

a) The person(s) responsible for ensuring the resident's care plan, including eMAR and eTAR, contains all requirements to document actions taken in respect to the assessment, reassessment, and monitoring, including the resident's response, every eight hours.

b) The person(s) responsible for implementing training to all staff who will be required to document the assessment, reassessment, and monitoring, including the resident's response while using physical devices. This training shall include where these actions will be documented. The training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

c) An auditing schedule to ensure that residents who use physical devices, have documentation that includes the assessment, reassessment, and monitoring, including the resident's response, every eight hours. Auditing shall continue until no further concerns arise with the completion of the required documentation. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented and included all assessment, reassessment and monitoring, including the resident's

response.

Two residents were observed to have a physical device in place. No documentation was in place regarding all assessment, reassesment and monitoring of the resident, including the resident's response, while the physical device was in place, every eight hours, and at any other time when necessary.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and had not included these requirements, when they moved from the previous paper documentation that had been in place.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Failure to document all assessments, reassessments and the resident's responses when using physical devices, had the potential to result in not providing care that met the safety and comfort needs of the residents.

Sources: resident care plans, progress notes, electronic documentation, and interviews with Registered staff and other staff. [s. 110. (7) 6.]

An order was made by taking the following factors into account:

Severity: There was minimal risk to both residents when the actions of assessing, reassessing and monitoring, including the resident's response while using physical devices, every eight hours, had not been documented.

Scope: This non-compliance was identified as a pattern as two out of three residents reviewed, had no documentation in place, for the required actions, performed by the staff.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 110(7) 6 and one Voluntary Plans of Correction (VPC) was issued to the home. (508)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 04, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee must be compliant with s. 110 (7) 7 of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure documentation for the identified residents, and any other resident using physical devices, includes every release of the device and all repositioning, every two hours.

The plan must include but is not limited to:

a) The person(s) responsible for ensuring the resident's care plan, including electronic documentation systems, contain all requirements to document actions taken in respect to every release of the device and all repositioning, every two hours.

b) The person(s) responsible for implementing training to all staff who will be required to document the above requirements. The training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

c) An auditing schedule to ensure that residents who use physical devices, have documentation that includes every release of the device and all repositioning, every two hours. Auditing shall continue until no further concerns arise with the completion of the required documentation. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that every use of a physical device used for two residents, as identified under section 31 of the Act, was documented, and included every release of the device and all repositioning, every two hours.

Two residents were observed to have a physical device in place. No documentation was in place regarding every release of the device and all repositioning, every two hours.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Sources: resident care plans, progress notes, electronic documentation , and interviews with PSW staff and other staff. [s. 110. (7) 7.]

An order was made by taking the following factors into account:

Severity: There was minimal risk to the identified residents when the actions of every releasing the physical device and all repositioning, every two hours, had not been documented.

Scope: This non-compliance was identified as a pattern as two out of three residents reviewed, had no documentation in place, for the required actions performed by the staff.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 110(7) 7 and one Voluntary Plan of Correction (VPC) was issued to the home. (508)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 04, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee must be compliant with s. 110 (7) 8 of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure documentation for the identified residents, and any other resident using physical devices, includes the removal of the device, time of removal and the post device care.

The plan must include but is not limited to:

a) The person(s) responsible for ensuring the resident's plan of care, including POC, contains all requirements to document actions taken in respect to the removal of the physical device, including the time of removal and post device care.

b) The person(s) responsible for implementing training to all staff who will be required to document the above requirements. The training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

c) An auditing schedule to ensure that residents who use physical devices, have documentation that includes the removal of the device, including the time of removal and post device care. Auditing shall continue until no further concerns arise with the completion of the required documentation. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 6, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that every use of a physical device used by two residents, as identified under section 31 of the Act, was documented, and included the removal of the device, including the time of removal and the post-device care.

Two residents were observed to have a physical device in place. No documentation was in place regarding the removal of the device, including the time of removal and post device care.

Staff acknowledged they had been aware of the requirement to document these required actions; however, the home had recently implemented an electronic documentation system and the tasks to document these requirements, had not been included in this system.

It was indicated when the home moved from paper documentation to an electronic documentation system, these requirements may not have been incorporated, resulting in staff not having a place to document these actions taken in regard to residents who used physical devices.

Failure to document the removal of the device, time of the removal and post-restraining care, had the potential to result in not providing safe and comfortable care to the resident.

Sources: resident care plans, progress notes, electronic documentation, and interviews with PSW staff and other staff. [s. 110. (7) 8.]

An order was made by taking the following factors into account:

Severity: There was minimal risk to the identified residents when the actions of removing the physical device, including the time of removal and post device care, had not been documented.

Scope: This non-compliance was identified as a pattern as two out of three residents reviewed, had no documentation in place, for the required actions performed by the staff.

Compliance History: In the last 36 months, the licensee was found to have previous non-compliance, none of which are the same subsection.
(214)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 04, 2022

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 20th day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathy Fediash

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