Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District

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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 22, 2022

Inspection Number: 2022-1432-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: 955464 Ontario Limited

Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

Lead Inspector	**Inspector Digital Signature**
Cheryl McFadden (745)	Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2022.11.23 08:08:38 -05'00'

Additional Inspector(s)
Susan Crann (741069)
Tatiana Pyper (733564)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 31, November 1, 2 and 3, 2022.

The following intake(s) were inspected:

Intake: #00003857- [CI: 2948-000003-22] related to fall's prevention.
Intake: #00006541- [CI: 2948-000010-22] related to fall's prevention.
Intake: #00002011- [CI: 2948-000016-22] related to fall's prevention.
Intake: #00003284- [CI: 2948-000017-21] related to fall's prevention.
Intake: #00005141- [CI: 2948-000018-22] related to fall's prevention.
Intake: #00001669- [CI: 2948-000019-22] related to prevention of abuse and neglect.
Intake: #00002377- [CI: 2948-000020-22] related to mandatory reporting requirements.
Intake: #00008507- [CI: 2948-000024-22] related to prevention of abuse and neglect.
Intake: #00002129-Complaint related to care and services and prevention of abuse and neglect.
Intake: #00011926-Complaint related to care and services, housekeeping.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2) FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care plan set out in the plan of care was provided for a resident as specified in the plan.

Observation of a resident room noted a specific assistive device for their bed was in place for a resident. Review of the resident plan of care and Kardex on Point Click Care (PCC) showed that the device was not to be used. Assistant Director of Care (ADOC) acknowledged that the device was not to be in place for the resident as per their plan of care and removed the device immediately. There was low risk to the resident at the time of the observation.

Sources: Observations of resident home areas, review of the resident clinical records, and interview with ADOC. [733564]

Date Remedy Implemented: November 1, 2022.

WRITTEN NOTIFICATION: Reporting

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was 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 5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
Record Review of Extendicare Policy RC-02-01-02 A2, "Jurisdictional Reporting Requirements", last reviewed January 2022, included a copy of the Ministry of Long-Term Care (MLTC) reporting requirements reference sheet, dated October 2022.

Record Review of Critical Incident Report #2948-000011-22 documented an Acute Respiratory Illness outbreak was declared by Public Health on April 29, 2022, at 1600, this was reported to the MLTC on May 3, 2022, at 1059.

Record Review of Critical Incident Report #2948-000017-22 documented a COVID outbreak was declared by Public Health on July 13, 2022, at 1000, this was reported to the MLTC on July 14, 2022, at 1418.

Record Review of Critical Incident Report #2948-000020-22, documented a COVID outbreak was declared by Public Health on August 14, 2022, at 1100, this was reported to the MLTC on August 15, 2022, at 1410.

Administrator #100 and ADOC #102, stated they were aware of mandatory reporting requirements, said the Critical Incident Reports were not submitted immediately and they should have been.

Sources: CIS #2948-000011-22, CIS #2948-000017-22, CIS #2948-000020-22, Extendicare Policy RC-02-01-02 A2, "Jurisdictional Reporting Requirements" and Staff Interviews. [745]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes updated June 2022, stated "Licensees are required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed".
COVID-19 guidance document for long-term care homes in Ontario, updated October 14, 2022, stated "Masks are required for long-term care staff, as well as for visitors and others entering long-term care homes," and "homes must ensure that all staff comply with masking requirements at all times.

Rationale and Summary
Inspector #745 observed a visitor sitting in the resident lounge without required (personal protective equipment) PPE on and six other residents in the room. When approached staff stated, "it was not their job to enforce masking".

A Personal Support Worker (PSW) was observed being less than six feet apart from a resident on the second-floor dining room of the home, without wearing required PPE and a PSW was observed in the dining-room without the required PPE on while feeding a resident.

In an interview, PSW acknowledged that they were supposed to wear a specific PPE when working in the home and while feeding a resident. In an interview, Assistant Director of Care (ADOC) stated that the PSW being less than six feet apart from a resident on the second-floor dining room, without wearing the required PPE did not meet the expectations of the home.

In an interview Administrator acknowledged staff were not following expected masking procedures at all times and they should be.

Sources: IPAC Observations, review of Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes updated June 2022, review of COVID-19 guidance document for long-term care homes in Ontario, updated October 14, 2022, and staff interviews. [733564] and [745]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 155 (1) (a).

Non-compliance with: LTCHA, 2007, s. 19 (1)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)] do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The licensee must:

A) Retrain registered nursing staff scheduled in Clifton home area on the home's Zero Tolerance of Resident Abuse and Neglect Program policy.

B) Retrain registered nursing staff in Clifton home area on the home's process of assessing, management, and monitoring of Urinary Tract Infection (UTI), and process of reporting of signs and symptoms of UTI.

C) Maintain records of the training provided, including, but not limited to, dates, times, attendees, trainers, and materials taught.

Rationale and Summary

The licensee has failed to ensure a resident was protected from being neglected by staff.

Ontario Regulations 246/22 defines "neglect" 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.

A complaint was received by the Long-Term Care ACTION Line, regarding concerns of possible neglect of a resident by staff members of the home.

Review of progress notes on Point Click Care (PCC) for the resident showed that on multiple occasions the resident complained to the staff of having pain. A follow-up on the resident symptoms was not made at the time.

In an interview, Registered Nurse (RN) stated that a follow up should have been made after the resident complained to the staff of having pain.

In an interview, Assistant Director of Care (ADOC) stated that a follow up should have been made after the resident complained to the staff of having pain.

In an interview, a Physician stated that it was expected that a follow up would have been made after the resident complained to the staff of having pain.

A review of the home's "Zero Tolerance of Resident Abuse and Neglect Program" policy, last reviewed January 2022, stated "Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated," and "This policy applies to all staff, agency/contractors, students, volunteers, families, visitors, board members, and individuals that are involved with the care of the resident and/or the safe operation of the home."

There was actual risk that occurred to the resident when they were not clinically assessed for a follow up of their symptoms after complaining to the staff.

Sources: Review of complaint IL03120-HA, review of a resident clinical records, review of home's "Zero Tolerance of Resident Abuse and Neglect Program" policy, last reviewed January 2022, interview with RN, ADOC and Physician. [733564]

This order must be complied with by December 12, 2022.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca
If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.