



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Nov 4, Dec 14, 16, 2011; 2011\_105130\_0021; Critical Incident

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

GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care and Assistant Director of care related to H-02000-11

During the course of the inspection, the inspector(s) interviewed staff, observed an identified resident and reviewed critical incident reports, clinical records and policies.

The following inspection protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. Legend: WN - Written Notification, VPC - Voluntary Plan of Correction, DR - Director Referral, CO - Compliance Order, WAO - Work and Activity Order. Legendé: WN - Avis écrit, VPC - Plan de redressement volontaire, DR - Aiguillage au directeur, CO - Ordre de conformité, WAO - Ordres : travaux et activités

|                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>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.)</p> | <p>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.</p> |
| <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>                                                                                                                                                         | <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>                                                                                                                                                                                        |

**WN #1: 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 subsections:**

**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**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. An identified resident sustained a fall in 2011 as a result of staff not following the plan of care related to bed rail use and not following policies and procedures related to medication administration and reconciliation upon return from hospital.

**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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.**

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs Specifically failed to comply with the following subsections:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. In 2011 an identified resident suffered ill effects requiring a transfer to hospital for assessment and treatment after an identified registered staff failed to follow medication administration directions prescribed by a physician.

**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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.**



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Rapport d'inspection  
prévus le Loi de 2007 les  
foyers de soins de longue

Issued on this 16th day of December, 2011

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

A handwritten signature in cursive script, appearing to read "Stacey", is written in the center of the signature box.