Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: August 13, 2024
Inspection Number: 2024-1432-0004
Inspection Type:
Complaint
Critical Incident

Licensee: 955464 Ontario Limited
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 22-25, 29-31, 2024

The following intakes were inspected:
- Intake: #00113842 and Intake: #00114677 related to Prevention of Abuse and Neglect.
- Intake: #00118864 - Anonymous complainant with concerns regarding Resident Care and Support Services, Pain Management, and Prevention of Abuse and Neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Pain Management

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)
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to comply with the "Employee Identification" policy when staff did not wear name badges while on duty.

Rationale and Summary

On a specified date, three staff were observed to not be wearing name badges while on duty. The "Employee Identification" policy dated January 2022 indicated that all staff must wear their name badge, at all times, and ensure it is clean and visible while on duty.

The Director of Care (DOC) stated name tags are to be kept visible to residents and that if staff were not wearing name badges, then they were not following the

home's policy.

Another observation was made on the same day, and the staff were observed to be wearing their name badges while on duty.

Sources: Observations on home area; Employee Identification policy; interviews with staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality.

Rationale and Summary

On more than one occasion, a specific staff person attempted to be affectionate towards a resident in a way that the resident did not appreciate. The staff person

acknowledged that the resident had asked them to stop, and they continued to do it anyway. They did not understand that this behaviour was inappropriate. The staff person was disciplined as a result and re-education was provided.

Failure to ensure that the rights of the resident were fully respected and promoted may have compromised the resident's quality of life and experience in the home.

Sources: Critical incident report, the home's internal investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident's right to proper care and services consistent with their needs was fully respected and promoted.

Rationale and Summary

A resident had a cognitive deficit and required total assistance from two staff for transfer in and out of the bath.

On a specified date, a staff person left the resident alone in the tub room to go and look for someone to help them transfer the resident out of the bath. The home's

policy titled "Bathing, Showering and Water Temperature Monitoring" indicated that direct care staff are not to leave residents alone in the bath tub or bath/shower area. Further, the resident was not cognitively able to call for help if needed.

Failure to provide the resident with proper care and services consistent with their needs had potential to increase risk of injury or harm to the resident.

Sources: Resident's plan of care, critical incident report, the home's internal investigation notes, policy titled "Bathing, Showering, and Water Temperature Monitoring", and interviews with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-term Care for suspected physical abuse of a resident by a resident. The suspicion was investigated by the home, however, the CIR was not amended to include the results of the investigation.

Sources: Critical Incident Report and interview with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to ensure that the the organized program of nutritional care and dietary services required under clause 15 (1) (a) of the Act included the implementation of interventions to mitigate and manage risks related to nutritional care and dietary services.

Rationale and Summary

A resident was on a texture modified diet and required one person extensive assistance for eating. On a specified date, a staff person was feeding the resident with the resident's eyes closed.

Staff indicated that where a resident has their eyes closed, they should not be feeding the resident due to risk for agitation and/or choking.

Failure to ensure that interventions to mitigate and manage risks related to nutritional care and dietary services were implemented put the resident at risk.

Sources: Critical incident report, the home's internal investigation notes, resident's

plan of care, and interviews with staff.