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

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Original Public Report

Report Issue Date: October 16, 2024
Inspection Number: 2024-1432-0005
Inspection Type: Proactive Compliance Inspection
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-12, 18-20, 23-24, and 26, 2024

The following intake(s) were inspected:

- Intake: #00126097 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that the plan of care for a resident was revised when the resident's care needs changed.

Rationale and Summary
A resident's plan of care indicated they preferred a specified activity of daily living (ADL). Documentation completed by staff indicated that the resident was provided a different specified ADL and two staff confirmed that the resident preferred that specified ADL instead.

The resident's plan of care also indicated that staff were to use a specified

equipment for care. On observation of the resident during care on a specified date, the resident was provided care with a different specified equipment and staff identified that equipment was used for all of the resident's specified ADL.

An Assistant Director of Care (ADOC) acknowledged that the resident's plan of care required revision for their current specified ADL preference and identified equipment use. The plan of care was updated accordingly prior to the completion of the inspection.

Sources: A resident's clinical records including plan of care and documentation survey report, specified ADL list, observations, and interviews with staff. [740882]

Date Remedy Implemented: specified date

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 23 (2) (e)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 246/22, s. 23 (2); O. Reg. 66/23, s. 3 (1).

The licensee has failed to ensure the home's heat related illness prevention and management plan included a protocol for appropriately communicating the heat related illness prevention and management plan to visitors and volunteers.

Rationale and Summary

The home's heat related illness prevention and management plan did not include the communication protocol of their plan to visitors and volunteers. The Director of Care (DOC) explained their communication protocols included volunteers and visitors but was not written in their plan. During the course of the inspection, the home's heat related illness prevention and management plan was revised and updated with the communication protocol to visitors and volunteers and when they were implemented.

Sources: Preventing Heat- Related Illnesses Policy, Heat Policy Review and Implementation 2024, and interview with the DOC.

Date Remedy Implemented: specified date

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 35 (4)

Nursing and personal support services

s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record of the dates of the summary of changes that were implemented in the home's annual staffing plan evaluation.

Rationale and Summary

The home's nursing staffing plan evaluation for 2024 did not include the written record of dates of the summary of changes that were implemented and was acknowledged by the DOC. During the course of inspection, the annual staffing plan evaluation was amended and included the dates of the changes to the 2024 staffing

plan were implemented.

Sources: Nursing Staffing Annual Evaluation 2024 and interview with the DOC.

Date Remedy Implemented: specified date

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 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 has failed to ensure that residents were treated with courtesy and respect that recognized their inherent dignity and worth.

Rationale and Summary
During the course of inspection, residents reported their concerns regarding staff speaking non-English languages in front of residents, in the dining rooms, the common areas, and in the hallways. Residents identified that they felt staff may be talking about them in another language.

On a specified date, two staff on a specified unit were observed speaking to each

other in a non-English language during the assistance and treatment to multiple residents. No residents were observed to converse back or speak the language spoken by staff.

The DOC acknowledged that staff should not be speaking to each other in another language in the presence of residents and that speaking in another language should be resident focused and involving the resident in conversation during care.

When staff failed to communicate in a manner that was appropriate while providing care for residents, there was a risk that the residents' inherent dignity and worth were impacted as they could not understand what was being communicated.

Sources: Observations, Resident's Bill of Rights, Resident Council Meeting Minutes, and interviews with residents and the DOC.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's rights for privacy in treatment and care was fully respected and promoted.

Rationale and Summary

On a specified date, a registered staff was observed providing a specified treatment to a resident in a common area. There were residents, a visitor, and staff members present in the area during the observation the treatment was provided.

The DOC acknowledged that any care or treatments should be performed in the resident's room for privacy and should not have been performed in a common area with multiple residents and a visitor present.

The right to quality care for a resident had not been fully respected and promoted when staff failed to ensure privacy while providing treatment and care.

Sources: Observations, Resident's Bill of Rights, and an interview with the DOC.

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented. Specifically, the home failed to ensure that documentation of a specified care for a resident was completed.

Rationale and Summary
A resident required a specified intervention schedule. A Point-Click-Care (PCC) task for the resident indicated that they were to be provided the intervention in a specified time. The resident was observed to be provided the specified intervention

on a specified date, however no documentation was completed.

Direct care staff were aware of the specified intervention schedule and referred to the residents plan of care as needed. The documentation survey report for a specified month date indicated that no documentation was made for the scheduled intervention provided. Registered staff confirmed there was no documentation for the specified month date as the documentation option for the task was not in place.

An ADOC acknowledged that they could not confirm the specified intervention was done as it was not documented, however direct care staff have plan of care access and knowledge of the intervention.

There was a risk that the resident would not have received the specified intervention as scheduled when there was no task listed on PCC.

Sources: A resident's clinical record and Documentation Survey Report, observations, and interviews with staff.

WRITTEN NOTIFICATION: Residents' Council- Duty to Respond

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents’ Council
s. 63 (3) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing.

The licensee has failed to respond in writing within 10 days of receiving the Residents' Council's (RC) identified concerns and recommendations about the

operation of the home.

Rationale and Summary
Staff identified that when RC has an identified concern or issues, that a concern form is filled out by the RC assistant and submitted to the appropriate member of the management team on the RC's behalf.

An interview with a member of the RC indicated that while the resident's feel they can bring forward any concerns to the RC meetings, they do not get a written response back on what has been done regarding their concerns.

A review of the RC meeting minutes from specified dates identified several issues, concerns, and suggestions for improvement that were raised by the RC, however issues on identified dates did not have a concern form nor response in writing submitted to the Council.

The RC advisor acknowledged that not all of the identified concerns were formally forwarded to appropriate management team members, and not all identified concerns had written responses provided to the Council within 10 days. The RC advisor confirmed that meeting minutes were submitted and reviewed by the home's Administrator as well.

By the home not responding to the Residents' Council in writing to address the Councils' identified concerns, there was a risk of the home not addressing the issues and concerns in a timely manner.

Sources: Interviews with a resident and staff, RC meeting minutes, and RC concern forms.

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that the home's cleaning and disinfection procedures of resident care equipment was implemented in accordance with evidence based practices.

Rationale and Summary
According to the home's Cleaning and Disinfecting Equipment Policy, resident care equipment that is shared among residents must be thoroughly cleaned and disinfected between each resident use to prevent the spread of infection.

On a specified date, two staff were observed using a specified equipment for resident care. Both staff were not observed to clean and disinfect the specified equipment before and after care. Both of the staff acknowledged that the specified equipment should be cleaned and disinfected after each resident use and that they both did not clean or disinfect the equipment after resident care.

Failure to ensure the home's cleaning and disinfection procedures were implemented posed a risk of transmission.

Sources: Observations, Cleaning and Disinfecting Equipment Policy, and interviews with staff.

WRITTEN NOTIFICATION: Security of Drug Supply

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2. i.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
2. Access to these areas shall be restricted to,
i. persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and

The licensee has failed to ensure steps were taken for the security of their drug supply, that included access to these areas be restricted to, persons, other than personal support workers (PSW), who may dispense, prescribe or administer drugs in the home.

Rationale and Summary
During an interview on a specified date, a registered staff reported concerns with PSWs having access to a specified medication room. The medication room contained specific medications in the refrigerator and other uncontrolled substances stored. Later in the day, a PSW was observed accessing the medication room through the door within the nursing station. The DOC acknowledged that the home's medication rooms were to be accessed by registered staff who possess the

keys and the keys are only kept with the designated nurse. The DOC stated that PSWs should not have access to the supply of medications and storage. The following day, the specified medication room door lock was changed and confirmed by the registered staff.

Failure to ensure access to a medication room was restricted only to the individuals as set out in legislation posed a risk for misuse and theft of resident medication.

Sources: Observations, Medication Room Policy, and interviews with staff and the DOC.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one employee of the licensee who was hired as a PSW.

Rationale and Summary
A review of the committee meeting minutes for the previous 12 months did not

include mention of PSW involvement, participation, or contribution to the meetings.

The home's administrator had shared that the CQI committee did not have membership of a PSW who worked at the home.

There was a risk that the input of direct care staff was not represented or considered for continuous quality improvement initiatives of the home when there was no PSW involvement in the CQI committee.

Sources: Interview with the Administrator/CQI lead, review of CQI meeting minutes, and review of the home's Terms of Reference for CQI Committee.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained the written record of the dates relating to when their resident and family/caregiver experience surveys (RFCE survey) were taken, the results of said survey, as well as the method of or dates of when the survey results were shared during the fiscal year.

Rationale and Summary
On review of the home's CQI initiative report and as acknowledged by the Administrator, a written record of required information was not included in the report. The CQI initiative report did not include the date in which their RFCE surveys were taken, the results of those surveys, or how and the dates when the survey results were communicated.

There was a potential risk that residents, families and staff of the home may not have been fully aware of the timeline of the home's efforts with regards to the initiation of or implementation of the RFCE surveys.

Sources: Home's CQI initiative report, review of website, and an interview with the Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were

communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the CQI initiative report contained the written record of how, and the dates of when, the actions taken to improve the home based on the results of the resident and family caregiver experience (RFCE) survey were communicated to the residents and their families, the Residents' Council, Family Council and members of the staff of the home.

Rationale and Summary
The home's 2024-2025 CQI initiative report did not include the written record of the required information mentioned above, as acknowledged by the Administrator.

Sources: Home's CQI initiative report, review of website, and an interview with the Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that the RC was provided with a copy of the most recent CQI initiative report.

Rationale and Summary

A review of the provided RC meeting minutes was completed and CQI initiative report section for all meeting minutes did not have mention or review of the CQI report, nor indication that a copy was provided.

The Administrator and Director of Therapeutic Recreation Services (DTRS) acknowledged that a copy of the CQI was not provided to the RC during Council meetings.

By the home failing to provide the RC with a copy of the most recent CQI initiative report, there was potential risk that residents would not be informed of the homes' identified areas of improvement.

Sources: Interview with the Administrator and DTRS, and a review of the RC and Family Council meeting minutes.