Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 10, 2013	2013_214146_0033	H-000084-13, H-000225-13	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

BARBARA NAYKALYK-HUNT (146)

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): May 29, 30, 31, 2013

This inspection was conducted concurrently with complaint inspections H-002012-12 and H-000206-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW'S), physiotherapy staff and residents.

During the course of the inspection, the inspector(s) reviewed policies and procedures, resident health records, post-falls evaluation documents and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. a. Resident #002's plan of care directed that the resident have a restraint in place in February 2013. In March 2013, the resident's restraint was not in place and the resident fell and was uninjured. The care set out in the plan was not provided.
b. Resident #001's plan of care directed that the resident was to have a safety alarm in place because of falls risk, initiated in September 2012. In February 2013, the resident fell. According to the post fall evaluation the safety alarm was not in place and was added post fall. The resident again fell in February 2013 without injury and the post fall evaluation stated the safety alarm was added on that date. The care was not provided as set out in the plan.
c. Resident #001's plan of care from September 2012, directed staff to stay with the resident during toileting. One week later, the resident had been put in the bathroom by staff, left unattended and was found on the floor uninjured. Care was not provided as set out in the plan.
d. Resident #001's progress notes in May 2013, directed that the resident was to have an appliance applied until a date in June 2013. When observed during this inspection, resident #001 had no appliance in place. Care as set out in the plan of care was not provided.
This information was confirmed by documentation in the health records, the post falls evaluation tools, observation and the DOC. [s. 6. (7)]

2. a. Resident #002 fell on a date in February 2013 and was injured. The resident fell again 2 days later and was injured. In March 2013, the resident fell again with no injury. Care plan revisions related to falls prevention after the first and second falls were not effective. No different approaches were considered.
b. Resident #001 fell in September 2012, October 2012, twice in February 2013, and in April 2013. No injuries occurred from the first 4 falls but the 5th fall resulted in fracture. Care plan revisions related to falls prevention were not effective. Alternate approaches were not considered .
c. Resident #001 undid a restraint in October 2012 as recorded in the progress notes. Later in October 2012, the resident again undid the restraint and fell as a result. There was no injury. The resident undid the restraint again 2 more times in October 2012 before an alternate approach was considered.
This information was confirmed by the health records and the DOC. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan and to ensure that:
when the resident is reassessed and the plan of care reviewed and revised, if the plan of care is revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 10th day of June, 2013

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

BARBARA NAYKALYK-HUNT.