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
Direction de l'amélioration de la performance et de la conformité

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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
Jul 30, 2013	2013_105130_0019	H-000356-13	Complaint

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 TRACEY (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 24, 25, 26, offsite July 3 and 4, 2013

PLEASE NOTE: The following inspections were conducted simultaneously with this inspection: H-00357-13/H-00358-13.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Assistant Director of Care, Physician, Registered Staff, personal support workers and residents.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed critical incident reports, reviewed relevant clinical records, policies and procedures and observed care related to H-00356-13.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse, by anyone. In 2013, Resident #001 received rough treatment by a personal support worker, while receiving care. A staff member witnessed another staff member twist the resident's arm; which caused the resident pain. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

a) The Home's policy: Abuse – Prevention, Reporting and Elimination of Abuse and Neglect [CA-05-37-2]indicated:

1. Uphold the right of residents of our Long Term Care(LTC)Homes to be treated with dignity and respect within those homes and be free from abuse and neglect as per the Residents' Bill of Right,

5. Investigate every alleged, suspected or witnessed incident of abuse and/or neglect,

7. Report to the police any alleged, suspected or witnessed incident of abuse or neglect that the home suspects may constitute a criminal offence,

8. Report to MOHLTC in accordance with the act and our reporting policy every alleged, suspected or witnessed incident of abuse and/or neglect,

9. The Administrator and/or designate must notify Ministry of Health and Long Term Care(MOHLTC) by phone immediately that an alleged, suspected or witnessed abuse or neglect has taken place or is likely to have taken place in accordance with the Long Term Care Homes Act(LTCHA) and the reporting policy,

10. Administrator and/or designate shall notify the resident's family members, substitute decision makers or others specified in the resident's plan of care as follows: immediately after Administrator becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

12. Where physical or sexual abuse has occurred or is suspected, the attending physician is to be contacted to arrange for a medical assessment.

b) Policy [CA-05-37-9] indicated:

1. Any persons who suspects that abuse or neglect has occurred must report it to the Registered staff who follows the same steps as of the abuse/neglect was witnessed,

2. Any person who witnessed a resident being abused must intercede and stop the abuse to prevent any further harm, Person committing the abuse refuses to come, the resident should be taken to ensure his/her safety,

3. Any person who witnessed a resident being abused is obligated to report it at once to the Registered staff and complete a written account of the incident which is turned into the Administrator within 24 hours of the incident,

4.Registered staff must contact the Administrator or his/her designate immediately for direction on sanctions to be imposed immediately and for direction on how to proceed with the investigation of any alleged, suspected or witnessed abuse or neglect.

c) Policy [CA-05-37-12] indicated:
1. Abused resident will be offered counseling and support services from management, staff and/or chaplain. Social work services and/or independent advocate services are available if requested.

d) In 2013, a personal support worker (psw) witnessed another psw make inappropriate statements to Resident #001, while attempting to provide care;despite the resident's continued protestations. The staff witnessed the resident display facial expressions of pain and verbally yell out in pain, when the staff member grabbed and twisted the resident's arm. The staff who witnessed the incident did not intervene and did not immediately report the incident in writing to Registered staff. The resident was not immediately assessed for injury and was not offered support services following the incident. The Administrator confirmed the incident was made known to Registered staff and management some time later in 2013; however it was not until sometime later that the MOHLTC was informed and an internal investigation commenced. The resident's substitute decision maker (SDM)and Physician were not notified of the incident until a later date in 2013. Police were not contacted until sometime later in 2013. [s. 20. (1)]

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 policy to promote zero tolerance of abuse by anyone and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the written policies and protocols developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home were implemented. The home's policy: Transcribing Physicians orders to MAR Sheet [8-3 (2)], indicated: a) Place an "X" through the entire box containing the medication order to be discontinued b) Draw a vertical line after the last dose c)Write D/C and then date and initial after the last dose given.

a)In 2012, the home transcribed admission medications from the hospital transfer records, which included a prn (as needed) antipsychotic medication. Orders were obtained from the physician as per the hospital transfer records. The home did not obtain consent from the resident/power of attorney (POA) for the administration of any of the admission orders. Later in 2012, a physician's order was obtained to administer the same medication routinely, twice a day. The POA initially consented to the administration of the routine medication, but later rescinded their consent. Due to the change in consent, staff noted on the MAR, beside the order, that family did not wish the resident to have the medication. Registered staff did not obtain a physician's order to discontinue the drug. The routine dose of the medication was removed from subsequent MARs; however, the prn dosage remained on the MARS during this time period. In 2013, the resident was administered a prn dose of the anti-psychotic medication without consent. Later in 2013, another routine dose of the medication was ordered with consent from the POA; however, the POA again rescinded consent before the medication was administered. An order was received sometime later in 2013, with instruction to discontinue the anti-psychotic; however, only the routine dose was discontinued from the MAR, the prn dose remained. [s. 114. (2)]

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 written policies and protocols developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home are implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's right to give or refuse consent to any treatment, care or service for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, was fully respected and promoted.

a) Staff did not obtain consent from Resident #001 or the resident's power of attorney (POA) for the administration of at least seven medications, which had been transcribed from hospital transfer records at the time of the resident's admission in 2012. The medication list included an anti-psychotic medication, which remained on the medication administration record forapproximatley ten months from 2012 until 2013, despite a number of requests from the POA that the resident not receive any anti-psychotic medications. Documentation and staff interviewed confirmed the resident received the medication on an identified date in 2013, without consent. [s. 3. (1) 11. ii.]

Issued on this 20th day of August, 2013

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

GILLIAN TRACEY

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2013_105130_0019
Log No. / Registre no:	H-000356-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 30, 2013
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MILLENNIUM TRAIL MANOR 6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents, including Resident #001, are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee did not ensure that every resident was protected from abuse, by anyone. In 2013, Resident #001 received rough treatment by a personal support worker, while receiving care. The staff witnessed another staff member twist the resident's arm; which caused the resident pain. (130)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of July, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office /
Bureau régional de services : Hamilton Service Area Office