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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5700 Yonge Street 5th Floor
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2016	2015_168202_0026	031827-15	Critical Incident System

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

Long-Term Care Home/Foyer de soins de longue durée

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

VALERIE JOHNSTON (202)

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): December 29, 30, 31, 2015.

During the course of the inspection, the inspector: reviewed clinical records, the home's night shift staffing schedule, call bell reports, home's policies related to fall prevention and continence care.

During the course of the inspection, the inspector(s) spoke with the administrator, associate nurse managers (ANMs), registered nursing staff, personal support workers.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
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
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).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #001, #002 and #003's plan of care identified the residents at high risk for falls and required staff assistance for toileting.

Interviews with RPN #100, PSW #101, PSW #107 and PSW #109 indicated that all three residents will request to be toileted and that staff must provide them immediate attention due to the high risk of falls associated with self- transferring. The staff further indicated that all three residents were never to be left unattended on the toilet, as it would not be safe.

The written plan of care for the above mentioned residents, states "do not leave the resident unattended while on the toilet".

On an identified date and approximate time, PSW #101 located him/herself in an identified area in order to monitor resident #003. PSW #101 indicated in an interview that it was at this time that resident #001's bedroom light turned on. PSW #101 stated that he/she left resident #003 to check on resident #001 who had requested assistance to the washroom.
PSW #101 further indicated that after assisting resident #001 onto the toilet, he/she heard resident #003 yelling for help from an identified area. PSW #101 indicated that he/she then left resident #001 on the toilet and attended to resident #003. Resident #003 was found to be in a compromised position and screaming to use the washroom. PSW #101 stated that it was at this time that he/she brought resident #003 to his/her room and assisted resident #003 onto the toilet.

While resident #003 and resident #001 were on the toilet, PSW #101 revealed that he/she heard resident #002's call bell ringing. The PSW further revealed that he/she left resident #003 on the toilet and immediately proceeded to resident #002's room. PSW #101 indicated that when resident #002 calls the resident required immediate assistance do to the associated risks of self-transferring.

Upon entry to resident #002's room, the PSW indicated that he/she found the resident to be standing by the bed in a compromised position. PSW #101 then left the resident's room to obtain supplies and then proceeded to assist resident #002 onto the toilet. PSW #101 then returned back to resident #001's bathroom.

PSW #101 confirmed that it was at this time that he/she found resident #001 lying on the bathroom floor and visibly injured. RPN #100 arrived immediately with the RN in charge. Resident #001 was then assessed and transferred to hospital for further assessment.

A review of resident #001's clinical records indicated that the resident returned to the home on an identified date for comfort care measures.

Resident #001 passed away two days after the identified date as a result of complications post fall.

An interview with the administrator indicated that upon completion of the home's investigation, it was confirmed that when resident #001 had been left unattended on the toilet on the identified date, the resident fell while attempting to self-transfer. The Administrator and PSW #101 both confirmed that the care set out in residents' #001, #002 and #003 plans of care had not been provided as specified.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The written plan of care for resident #001, #002 and #003 directed staff to "not leave unattended on the toilet". On an identified date and time, PSW #101 left residents #001, #002 and #003 unattended while they were on the toilet. Subsequently resident #001 was found on the floor of his/her washroom visibly injured and required a transfer to hospital for further assessment. The resident subsequently passed away as a result of the fall.
The scope of the non-compliance is isolated.
A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007. c.8.s 6 (7).: A written notification was previously issued for s. 6 (7) during a Resident Quality Inspection on February 06, 2015, under Inspection 2015_157210_0003 and a Voluntary Plan of Correction (VPC) was previously issued for the same during a Resident Quality Inspection on May 26, 2014, under Inspection 2014_369153_0002. [s. 6. (7)]

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan must, provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

Residents #001, #002 and #003 all reside on an identified home area and were assigned to PSW #101, on an identified date and shift.

An interview with PSW #101 indicated that on the identified shift and date and within an approximate time frame of 15 minutes, he/she assisted residents #001, #002 and #003 to the toilet. The PSW indicated that he/she had to leave each of the residents on the toilet in order to respond immediately to the call of each of the three high risk residents. At the end of the 15 minutes, PSW #101 indicated that when he/she returned to resident #001's bathroom, he/she found the resident lying on the floor and visibly injured. The resident was subsequently transferred to hospital and returned to the home on an identified date for comfort care. The resident passed away two days after the return to the home as a result of complications and injury from the fall.

A review of resident #001, #002 and #003's written plan of care identified the residents at

a high risk for falls and require staff assistance for all transfers. As of the above mentioned identified date of incident, the written plan of care for the above mentioned residents directed staff to "not leave the resident unattended while on the toilet".

An interview with ANM #104 revealed that following the home's investigation of the incident, he/she had been directed to review all resident care plans in the home for the inclusion of the intervention, "do not leave unattended on the toilet". The ANM indicated that the direction received from the DOC and the administrator was to remove the above mentioned intervention from all care plans and the families of the residents that had been affected by this change were to be informed. The ANM further revealed that the removal of the above mentioned intervention was in response to the home not having enough direct care staff on an identified shift to respond to all the residents that required toileting assistance.

A review of the home's investigation notes of the above mentioned incident, stated "contact all families with the intervention of: do not leave unattended while on toilet, explain that we cannot meet this demand and if families are wanting this intervention they will have to provide a private duty to meet this need".

Interviews with RPN #100, PSW #101, PSW #107 and PSW #109 revealed an awareness that the plan of care for the above mentioned residents had been changed and received the following direction. If staff had to leave a resident on a toilet to attend to another resident, they were to leave the resident on the toilet with the call bell in his/her hand.
When asked whether resident #002 and #003 could use a call bell, staff replied, that neither resident would remember to use the call bell and both residents would not be safe left unattended on the toilet.

An interview with the administrator indicated that removing the intervention "do not leave unattended on the toilet" from all care plans was to reduce staff demand. During the interview the administrator acknowledged that the above mentioned residents had identified care and safety needs and that the identified shift staffing plan did not meet the requirements set out in the Act and Regulations.

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 staffing plan must, provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2015_168202_0026
Log No. / Registre no:	031827-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2016
Licensee / Titulaire de permis :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
LTC Home / Foyer de SLD :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karie Warnar

To MILL CREEK CARE CENTRE, 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. 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).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. Within one week of receipt of this order, conduct a meeting between management and direct care staff from the identified home area. The meeting must include the night shift staff.

2. The meeting shall allow direct care staff the opportunities to communicate and evaluate the resident care and safety needs for the residents on the identified home area, for all three shifts.

3. Review the written plans of care for all residents in the home. The review shall ensure that the care set out in each of the plans is based on an assessment of residents' toileting needs.

4. The review shall not be limited to resident #002 and #003.

5. The home must review the home's night staffing plan and ensure that the staffing mix is consistent with residents' care and safety needs as indicated through the completion of steps 1, 2, 3 and 4.

6. Provide a plan to the inspector, identifying when all above mentioned steps will be completed.
The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion.
The plan is to be submitted to valerie.johnston@ontario.ca by March 18, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #001, #002 and #003's plan of care identified the residents at high risk for falls and required staff assistance for toileting.

Interviews with RPN #100, PSW #101, PSW #107 and PSW #109 indicated that all three residents will request to be toileted and that staff must provide them immediate attention due to the high risk of falls associated with self- transferring. The staff further indicated that all three residents were never to be left unattended on the toilet, as it would not be safe.

The written plan of care for the above mentioned residents, states "do not leave the resident unattended while on the toilet".

On an identified date and approximate time, PSW #101 located him/herself in an identified area in order to monitor resident #003. PSW #101 indicated in an interview that it was at this time that resident #001's bedroom light turned on. PSW #101 stated that he/she left resident #003 to check on resident #001 who had requested assistance to the washroom.

PSW #101 further indicated that after assisting resident #001 onto the toilet, he/she heard resident #003 yelling for help from an identified area. PSW #101 indicated that he/she then left resident #001 on the toilet and attended to resident #003. Resident #003 was found to be in a compromised position and screaming to use the washroom. PSW #101 stated that it was at this time that he/she brought resident #003 to his/her room and assisted resident #003 onto the toilet.

While resident #003 and resident #001 were on the toilet, PSW #101 revealed that he/she heard resident #002's call bell ringing. The PSW further revealed that he/she left resident #003 on the toilet and immediately proceeded to resident #002's room. PSW #101 indicated that when resident #002 calls the resident required immediate assistance do to the associated risks of self-transferring.

Upon entry to resident #002's room, the PSW indicated that he/she found the resident to be standing by the bed in a compromised position. PSW #101 then left the resident's room to obtain supplies and then proceeded to assist resident

#002 onto the toilet. PSW #101 then returned back to resident #001's bathroom.

PSW #101 confirmed that it was at this time that he/she found resident #001 lying on the bathroom floor and visibly injured. RPN #100 arrived immediately with the RN in charge. Resident #001 was then assessed and transferred to hospital for further assessment.

A review of resident #001's clinical records indicated that the resident returned to the home on an identified date for comfort care measures.

Resident #001 passed away two days after the identified date as a result of complications post fall.

An interview with the administrator indicated that upon completion of the home's investigation, it was confirmed that when resident #001 had been left unattended on the toilet on the identified date, the resident fell while attempting to self-transfer. The Administrator and PSW #101 both confirmed that the care set out in residents' #001, #002 and #003 plans of care had not been provided as specified.

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The scope of the non-compliance is isolated.
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(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2016

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 18th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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