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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 6, 2017	2017_414110_0007	028493-16, 028700-16, 028723-16, 029083-16, 029672-16, 034630-16, 035108-16, 000235-17, 001449-17, 007338-17, 008965-17, 009486-17, 017537-17	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

DIANE BROWN (110), CECILIA FULTON (618), JENNIFER BROWN (647)

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 31, June 1, 2, 6, 7, 8, 9, 12, 13, 14, August 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 2017.

During this RQI inspection the following CI (critical incidents) were inspected:
Log #008965-17, related to the managing of responsive behaviours.
Log #034630-16, related to an allegation of staff to resident abuse.
Log #028700-16, related to an allegation of resident to resident abuse.
Log #009486-17, related to the managing of responsive behaviours.
Log #028723-16, related to an allegation of staff to resident abuse.
Log #001449-17, related to an allegation of staff to resident abuse.
Log #017537-17, related to alleged missing medications completed.
Log #028493-16, related to an allegation of staff to resident abuse.
Log #029083-16, related to falls prevention.
Log #029672-16, related to an allegation of staff to resident. abuse.
Log #035108-16, related to falls prevention.
Log #000235-17, related to falls prevention.
Log #007338-17, related to infection control and prevention
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During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Director of Care (DOC), newly hired Director of Care (DOC #2), Administrator, Physiotherapist (PT), Food Service Manager, Dietary Aide, Nursing Managers (NM), Environmental Services Manager, Behaviour Care Support Worker, Manager of Clinical Information, Support Services Manager, Manager of Informatics, Residents and Families.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
1 VPC(s)
2 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. 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 has failed to ensure that residents were protect from abuse by anyone.

This inspection was initiated to inspect items identified in a Critical Incident (CI), related to an allegation of resident to resident abuse.

Record review revealed that on an identified date, resident #033 complained to staff #101 that resident #034 had entered his/her room, exhibited an identified responsive behaviour toward resident #033 and caused resident #033 pain.

Interview with registered staff #101 revealed that resident #033 spoke with him/her shortly after the incident to tell him/her what had happened. Resident #033 was described as being upset, crying and overwhelmed when he/she was telling staff #101 what had happened.

Staff #101 revealed that when they next observed resident #034, his/her behaviour was how he/she normally presented.

Record review revealed that staff continued to monitor resident #033's over the next few days and resident #033's injury was still painful..

A physician note following the identified incident, revealed test results of an identified injury to resident #033's identified area of his/her body.

Interview with resident #033 was not revealing as to the details of what occurred and resident #034 was not able to participate in an interview.

Review of resident #034's clinical records revealed that he/she had responsive

behaviours.and interventions had been identified in the written plan of care.

During the course of the inspection, resident #034 was observed with a behaviour on the unit and sitting in the common area. He/she was not observed often to be working at an identified activity and was never observed to demonstrate the identified responsive behaviours.

Interview with ADOC, staff #107 revealed that resident #033 had not been protected from abuse. [s. 19. (1)]

2. This inspection was initiated to inspect items identified in a CI report, related to alleged resident to resident abuse.

Record review revealed that on an identified date, resident #035 was found in the room of resident #036 and resident #035 exhibited an identified responsive behaviour with resident #036. Resident #036 was reported to be shook up by the incident and an assessment revealed an injury to resident #036.

Resident #035 was not available for observation or interview during this inspection and resident #036 was unable to provide information about this incident.

Interview with PSW #139 revealed that resident #035 had a behaviour and he/she believed the resident was a safety risk to co-residents.

Review of resident #035's written plan of care identified that he/she was at high risk for responsive behaviours. Interventions were identified in the written plan of care.

Review of a responsive behavior note, on an identified date, stated resident #035's behaviour was upsetting to co-residents and there was a risk of resident #035 harming himself or others.

A further responsive behaviour note, on an identified date, stated that resident #035 was a risk for exhibiting an identified responsive behaviour and could cause harm to other residents.

Interview with ADOC #107 confirmed that resident #036 had not been protected from abuse. [s. 19. (1)]

3. This inspection was initiated to inspect items identified in a CI report, related to an incident of resident to resident abuse.

Record review revealed that on an identified date, resident #031 was found exhibiting an identified responsive behaviour toward resident #032.

Record review revealed that resident #032 stated that resident #031 came into his/her room during the night and exhibiting an identified responsive behaviour towards his/her identified body area. Resident #032 indicated in this note that he/she was not physically injured, but that he/she did feel violated. A physical exam revealed no pain or injury.

Interview with ADOC, staff #107 confirmed that this incident had occurred and that resident #032 had not been protected from abuse. [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. 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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CI report, on an identified date, indicating that there had been an incident that caused an injury to resident #014 for which the resident had been taken to the hospital and had further resulted in a significant change in health status.

A review of resident #014's clinical records revealed that resident #014 had been admitted on an identified date. On admission, resident #014 had been identified as being independent with a mobility aide and identified through a fall risk assessment to be a specific risk level and requiring specific interventions including the use of a safety device as appropriate.

A review of the progress notes for resident #014, indicated that on the day of the incident, seven months following admission, that resident #014 lost his/her balance and fell. The progress notes further indicated that resident #014 had been assessed by RPN #119 and it had been determined that the resident had the physical characteristics of a significant injury and was transferred to hospital and later had an identified medical intervention..

A review of the current plan of care under the focus of risk for falls for resident #014 indicated resident was to have a safety device while up.

On an identified date, during this inspection, it had been observed that resident #014 was without the safety device in place.

Interview with PSW #111 who had been responsible for the care of resident #014 that day acknowledged the safety device was not applied or correctly in place. PSW #111 further indicated that resident #014 was unable to ambulate safely and also was not aware the resident was a fall risk.

An interview with RPN #115 indicated that safety devices were provided to residents who are at risk of falling, that lack insight of the safety risk of self-ambulating, and who are not able to request assistance from staff to ambulate or transfer. RPN #115 acknowledged that the plan of care focus of having a safety device in place for resident #014 was a current care plan intervention. RPN #115 further acknowledged that resident #014 was at risk of falling and was expected to have the safety device in place when up at all times.

An interview with the Director of Care and Nurse Manager #121 confirmed during an interview that resident #014 was at a high risk for falls and required the safety device when up and confirmed that the resident did not receive the care as required on the

identified date during the inspection. [s. 6. (7)]

2. The home submitted a CI report indicating that there had been an incident that caused an injury to a resident for which the resident had been taken to the hospital and had further resulted in a significant change in health status.

A review of resident #013's clinical records revealed that resident #013 had been admitted five weeks prior to the reported CI, and had been identified through a fall risk assessment to be at a high risk level and required interventions specific to the risk level including safety devices as appropriate.

A review of the progress notes for resident #013, indicated that on the day of the incident, PSW #122 had assisted resident #013 during morning care. While PSW #122 left resident in an identified manner, resident #013 slipped and fell to the floor. The progress notes further indicated that resident #013 had been assessed by RPN #123 and it had been determined that resident had physical characteristics of a significant injury and had been transferred to hospital and later had an identified medical intervention.

A review of the plan of care at the time of the above mentioned incident, under the focus of risk for falls, indicated that resident #013 had been at high risk for falls, including the need for safety devices while up.

Interviews with PSW's #111, #116, and #117 all indicated that resident #013 had been identified at high risk for falls and had current interventions in place to prevent falls. PSW #117 further indicated that resident #013 had been unable to ambulate safely.

An interview with RPN #118 indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The RPN further confirmed that the written plan of care for resident #013 had indicated that he/she had been identified as a high risk for falls and should not have been left alone in the identified manner during morning care.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to ensure the care set out in the plan of care is provided to the resident as specified in the plan. The DOC acknowledged during the above mentioned interview that resident #013 had not received care as specified in the plan of care and resident #013 should not have been left alone in the identified manner. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective.

This inspection was initiated to inspect items identified in a CI report, related to an allegation of resident to resident abuse and having exhibited an identified responsive behaviour towards staff and co-workers. The resident was identified as not being easily redirected.

Review of resident #035's written plan of care directed staff to use identified techniques to direct resident and to re-direct resident when he/she is exhibiting the identified behaviour.

Record review revealed that resident #035 had four identified interactions with co-residents in the months preceding the identified reported incident.

Documentation revealed these incidents were upsetting to co-residents, time consuming for staff and that resident #035 presented a risk of harming self or co-residents.

Interview with PSW #138 revealed that he/she felt resident #034 was a safety risk to both co-residents and staff and that monitoring of resident #034 was not effective to decrease the risk. PSW #138 revealed that two identified interventions had been tried but were not an effective deterrent to resident #034's behaviour.

Review of resident #034's annual care conference, prior to the identified incident reported, revealed that the resident required an identified intervention for behaviours. Record review did not provide evidence that this intervention was implemented and an interview with several staff members including the DOC revealed that identified intervention was not realistic.

Interview with ADOC, staff #107 revealed that following the reported CI that medication changes had been implemented but that the resident had not been assessed and care plan reviewed and revised when the above interventions had not been effective to manage resident #034's responsive behaviours. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity are fully respected and promoted.

The home contacted the MOHLTC ACTION line on an identified date, and subsequently submitted a CI report indicating that there had been an allegation of staff to resident abuse/neglect.

A review of resident #001's clinical records revealed that resident #001 informed staff on an identified date, that PSW #114 made a request to resident #001 during care which left resident #001 feeling degraded and humiliated.

A review of the progress notes for resident #001, indicated that resident #001 had been independent with his/her own care. The progress notes further indicated that PSW #114 entered resident #001's room and stated that he/she had to provide care in an identified manner to resident #001. Resident #001 inquired why this was necessary since resident #001 was independent with his/her care. The progress notes indicated that PSW #114 responded by stating that he/she had to provide this care.

During an interview with resident #001, he/she had emotionally disclosed the above mentioned incident and indicated that this left him/her feeling humiliated. Resident #001

indicated that he/she was a very private person and had never had that request from staff prior to the incident mentioned above.

Interview with RPN #108 indicated that resident #001 had reported the above incident to him/her on an identified date, when he/she had been completing rounds. RPN #108 further indicated that resident had been very emotional when informing RPN #108 of the previous evening's incident and stated that he/she felt degraded.

Inspector had attempted to reach PSW #114 by telephone on three occasions and left messages after each attempt and PSW #114 had not returned the calls.

A review of the home's investigation notes indicated that PSW #114 had been interviewed relating to the incident above and re-educated on code of conduct, abuse and neglect, and resident rights prior to returning to the unit.

Interview with Associate Director of Care #107 acknowledged the above mentioned incident and further indicated that all residents are to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. ADOC #107 confirmed that resident #001 had not been treated with dignity and have not been provided respect related to the above mentioned incident. [s. 3. (1) 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 resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity are fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place were complied with.

This inspection was initiated to inspect items identified in a CI report, related to an incident of resident to resident abuse.

Review of the home's policy titled Abuse and Neglect Policy, dated December 19, 2000, revised March 17, 2017, revealed in bullet #15 that upon discovering an incident of suspected or witnessed abuse, a staff member is to prepare a written report, which contains the following information and it to be provided to their Supervisor: a. what occurred, b. when it occurred, c. who was involved, including witnesses d. where it occurred, and e. any other relevant information.

Review of the CI report revealed that the report was submitted on an identified date. Record review revealed that the incident of alleged abuse involving resident #031 and #032 occurred three days prior, and that this incident had not been documented or reported as required under the above mentioned policy.

Interview with registered staff #140 revealed that he/she had not completed this report or reported the incident to anyone other than the oncoming shift staff.

Interview with the ADOC, staff #107 revealed that the requirements of this policy item can be fulfilled by the completion of an incident report and the ADOC also confirmed that no incident report had been completed for this incident. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone.

The home contacted the Ministry of Health and Long Term Care emergency pager on an identified date, at 0854 hours related to an incident of abuse that occurred the day before, at 2150 hours. The home subsequently submitted a CI report two days following the incident, at 1301 hours.

A review of the critical incident report indicated that resident #015 entered the room of resident #016. The report further indicated that staff found both residents in resident #016's room and observed resident #015 with injuries. Both residents had been assessed at the time of the incident and required no further interventions.

During an interview, the Director of Care indicated that staff are educated on the reporting requirements and the expectations of mandatory reporting. The Director of Care indicated that RN #124 had suspected abuse and notified the Ministry of Health and Long Term Care through the emergency pager late and not within the legislative requirements if there had been suspected abuse.

The DOC confirmed that the above mentioned incident had been suspected as the incident had been unwitnessed. The DOC further confirmed that the suspected abuse should have been reported immediately to the Director when it occurred in the evening of May 13, 2017. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

This inspection was initiated to inspect items identified in a CI report, related to an incident of resident to resident abuse.

Record review revealed that resident #031 demonstrated responsive behaviours and that interventions to manage the behaviours were identified.

Interview with PSW #138 revealed that resident #031 often had behaviours and that it was very hard to re-direct him/her. PSW #138 revealed that interventions were not effective for resident #031's behaviour and that he/she felt resident #031 was a safety risk to staff and co-residents.

Interview with registered staff #140 who often worked night shift revealed that resident #031 exhibited behaviours. Staff #140 revealed that resident #031 was known to have an identified behaviour and further revealed that he/she believed this behavior was known by other staff members.

Interview with PSW # 141, who often worked night shift revealed that resident #031 had behaviours and that he/she had reported the behaviors on many occasions including to

the ADOC and staff #107. PSW #141 revealed that effective monitoring of the resident was not possible on night shift.

Review of progress notes revealed several occasions where an intervention was used to manage resident's identified behaviours overnight prior to the reported CI. Review of resident #031's written plan of care did not include this identified intervention.

Review of progress notes revealed documentation of resident exhibiting an identified behaviour prior to the reported CI.

Review of physician note, on an identified date prior to the reported CI, revealed that the physician was not aware of any previous identified behavior as they describe this as a new behavior.

Interviews with registered staff #142 and #139, both of which often worked nights, revealed that resident #031 had behaviours but were unaware of the identified behaviour towards co-residents.

Interview with ADOC, staff #107 revealed that he/she was not aware of resident #031 demonstrating any identified behavior towards co-residents.

Review of clinical notes and interviews with staff revealed that staff did not have the same information regarding resident #031's behaviours, particularly as it pertained to his/her identified behaviours. It was evident that the exchange of information that may have minimized potential resident risk had not occurred.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home:

An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The home submitted a CI report to the Ministry of Health and Long Term Care on October 11, 2016, at 1444 hours to report a confirmed respiratory outbreak that had been declared by Public Health on October 3, 2016 which involved six residents.

Additionally, the home submitted another CI report to the Ministry of Health and Long Term Care on April 7, 2017, at 1323 hours for a respiratory outbreak that had been declared on March 31, 2017, involving eight residents.

During an interview, the Director of Care indicated that staff were educated on the reporting requirements and the expectations around them. The DOC confirmed that the above mentioned CI reports had not been submitted to the Ministry of Health and Long Term Care as required by legislation. [s. 107. (1)]

Issued on this 11th day of October, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), CECILIA FULTON (618), JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2017_414110_0007
Log No. / No de registre :	028493-16, 028700-16, 028723-16, 029083-16, 029672-16, 034630-16, 035108-16, 000235-17, 001449-17, 007338-17, 008965-17, 009486-17, 017537-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 6, 2017
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 :	Kyla MacDonald

To MILL CREEK CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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 :

Within 30 days of receiving this order, the Licensee shall conduct meeting(s) with all direct care staff.

The purpose of the meeting(s) are to:

a. Review and have staff demonstrate an understanding of the prevention of abuse policy, each individual staffs reporting responsibilities with regards to alleged or suspected abuse, and the definitions of abuse as defined in the LTCA, 2007, and their duty to protect residents from abuse.

b. Develop a template to use during Behaviour Support meetings which clearly captures the discussion items and action plans and identifies who will complete the action steps and provides a time frame for completion of action steps.

c. Maintain a record of who attended the meeting(s), when the meeting(s) were held and what information was provided at the meeting(s).

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protect from abuse by anyone.

This inspection was initiated to inspect items identified in a CI report related to an incident of resident to resident abuse.

Record review revealed that on an identified date, resident #031 was found exhibiting an identified responsive behaviour toward resident #032.

Record review revealed that resident #032 stated that resident #031 came into his/her room during the night and exhibiting an identified responsive behaviour towards his/her identified body area. Resident #032 indicated in this note that he/she was not physically injured, but that he/she did feel violated. A physical exam revealed no pain or injury.

Interview with ADOC, staff #107 confirmed that this incident had occurred and that resident #032 had not been protected from abuse.
(618)

2. This inspection was initiated to inspect items identified in a CI report related to alleged resident to resident abuse.

Record review revealed that on an identified date, resident #035 was found in the room of resident #036 and resident #035 exhibited an identified responsive behaviour with resident #036. Resident #036 was reported to be shook up by the incident and an assessment revealed an injury to resident #036.

Resident #035 was not available for observation or interview during this inspection and resident #036 was unable to provide information about this incident.

Interview with PSW #139 revealed that resident #035 had a behaviour and he/she believed the resident was a safety risk to co-residents.

Review of resident #035's written plan of care identified that he/she was at high risk for responsive behaviours. Interventions were identified in the written plan of care.

Review of a responsive behavior note, on an identified date, stated resident #035's behaviour was upsetting to co-residents and there was a risk of resident #035 harming himself or others.

A further responsive behaviour note, on an identified date, stated that resident #035 was a risk for exhibiting an identified responsive behaviour and could cause harm to other residents.

Interview with ADOC #107 confirmed that resident #036 had not been protected from abuse.

(618)

3. This inspection was initiated to inspect items identified in a CI report related to an allegation of resident to resident abuse.

Record review revealed that on an identified date, resident #033 complained to staff #101 that resident #034 had entered his/her room, exhibited an identified responsive behaviour toward resident #033 and caused resident #033 pain.

Interview with registered staff #101 revealed that resident #033 spoke with him/her shortly after the incident to tell him/her what had happened. Resident #033 was described as being upset, crying and overwhelmed when he/she was telling staff #101 what had happened.

Staff #101 revealed that when they next observed resident #034, his/her behaviour was how he/she normally presented.

Record review revealed that staff continued to monitor resident #033's over the next few days and resident #033's injury was still painful..

A physician note following the identified incident, revealed test results of an identified injury to resident #033's identified area of his/her body.

Interview with resident #033 was not revealing as to the details of what occurred and resident #034 was not able to participate in an interview.

Review of resident #034's clinical records revealed that he/she had responsive behaviours.and interventions had been identified in the written plan of care.

During the course of the inspection, resident #034 was observed with a behaviour on the unit and sitting in the common area. He/she was not observed often to be working at an identified activity and was never observed to demonstrate the identified responsive behaviours.

Interview with ADOC, staff #107 revealed that resident #033 had not been protected from abuse.

The scope of this finding was widespread, the severity was identified as actual

harm and risk and the home does have a compliance history . The compliance history report showed ongoing non-compliance with a CO issued during inspection 2016_414110_0008 on August 16, 2016. As a result of scope, severity and previous compliance history a compliance order has been issued. (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

Order # / Ordre no : 002

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 a receipt of this order the licensee shall, develop and submit a plan that includes the following requirements and the person responsible for completing the tasks. The plan is to be submitted to jennifer.brown6@ontario.ca by October 19, 2017.

1. Provide hands on training to all direct care staff in the home to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specific to fall prevention interventions, including but not limited to chair sensor alarms.
2. Maintain record of the content of the training in-service and all staff in attendance.
3. A record of staff signatures acknowledging when education has been received and understood.

Grounds / Motifs :

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

The home submitted a CI report indicating that there had been an incident that caused an injury to a resident for which the resident had been taken to the hospital and had further resulted in a significant change in health status.

A review of resident #013's clinical records revealed that resident #013 had been admitted five weeks prior to the reported CI, and had been identified through a fall risk assessment to be at a high risk level and required interventions specific to the risk level including safety devices as appropriate.

A review of the progress notes for resident #013, indicated that on the day of the incident, PSW #122 had assisted resident #013 during morning care. While PSW #122 left resident in an identified manner, resident #013 slipped and fell to the floor. The progress notes further indicated that resident #013 had been assessed by RPN #123 and it had been determined that resident had physical characteristics of a significant injury and had been transferred to hospital and later had an identified medical intervention.

A review of the plan of care at the time of the above mentioned incident, under the focus of risk for falls, indicated that resident #013 had been at high risk for falls, including the need for safety devices while up.

Interviews with PSW's #111, #116, and #117 all indicated that resident #013 had been identified at high risk for falls and had current interventions in place to prevent falls. PSW #117 further indicated that resident #013 had been unable to ambulate safely.

An interview with RPN #118 indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The RPN further confirmed that the written plan of care for resident #013 had indicated that he/she had been identified as a high risk for falls and should not have been left alone in the identified manner during morning care.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to ensure the care set out in the plan of care is provided to the resident as specified in the plan. The DOC acknowledged during the above mentioned interview that resident #013 had not received care as specified in the plan of care and resident #013 should not have been left alone in the identified manner.

(647)

2. The home submitted a CI report, on an identified date, indicating that there had been an incident that caused an injury to resident #014 for which the resident had been taken to the hospital and had further resulted in a significant change in health status.

A review of resident #014's clinical records revealed that resident #014 had been admitted on an identified date. On admission, resident #014 had been identified as being independent with a mobility aide and identified through a fall risk assessment to be a specific risk level and requiring specific interventions including the use of a safety device as appropriate.

A review of the progress notes for resident #014, indicated that on the day of the incident, seven months following admission, that resident #014 lost his/her balance and fell. The progress notes further indicated that resident #014 had been assessed by RPN #119 and it had been determined that the resident had the physical characteristics of a significant injury and was transferred to hospital and later had an identified medical intervention..

A review of the current plan of care under the focus of risk for falls for resident #014 indicated resident was to have a safety device while up.

On an identified date, during this inspection, it had been observed that resident #014 was without the safety device in place.

Interview with PSW #111 who had been responsible for the care of resident #014 that day acknowledged the safety device was not applied or correctly in place. PSW #111 further indicated that resident #014 was unable to ambulate safely and also was not aware the resident was a fall risk.

An interview with RPN #115 indicated that safety devices were provided to residents who are at risk of falling, that lack insight of the safety risk of self-ambulating, and who are not able to request assistance from staff to ambulate or transfer. RPN #115 acknowledged that the plan of care focus of having a safety device in place for resident #014 was a current care plan intervention. RPN #115 further acknowledged that resident #014 was at risk of falling and was expected to have the safety device in place when up at all times.

An interview with the Director of Care and Nurse Manager #121 confirmed during an interview that resident #014 was at a high risk for falls and required the safety device when up and confirmed that the resident did not receive the care as required on the identified date during the inspection.

The scope of this finding was pattern, the severity was identified as actual harm and risk and the home does have a compliance history . The compliance history

report showed ongoing non-compliance with a WN issued May 31, 2017, during inspection 2017_491647_0010, a VPC issued August 16, 2016, during inspection 2016_414110_0008 and a CO issued December 29, 2015, during inspection 2015_168202_0026. As a result of scope, severity and previous compliance history a compliance order has been issued. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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