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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2019_657681_0006	025901-18, 027016-18	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

STEPHANIE DONI (681)

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): February 26 - March 1, 2019.

The following intakes were inspected on during this Critical Incident System inspection:

- One intake related to a fall that resulted in injury to a resident.

- One intake related to improper treatment of a resident that resulted in harm or risk to a resident.

A Follow up inspection #2019_657681_0005 was conducted concurrently with this inspection.

PLEASE NOTE: A Written Notification (WN) related to s. 19 (1) of the LTCHA, 2007, was identified in this inspection and has been issued in Inspection Report #2019_657681_0005, dated March 12, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Clinical Nurse Consultant, Nurse Managers, Manager of Clinical Informatics and Quality Improvement, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Program Therapist, Personal Support Workers (PSWs), family members, and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

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

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

1 WN(s)
0 VPC(s)
0 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	Légende 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

A Critical Incident (CI) report was submitted to the Director related to a fall for which the resident was taken to hospital and that resulted in a significant change to the resident’s health status. The CI report indicated that, on a particular date, resident #001 sustained a fall which resulted in a specific injury to the resident.

On a particular date, Inspector #681 observed resident #001 sitting in the lounge area of a specified unit. The Inspector observed that the resident had a specified intervention in place.

The Inspector reviewed resident #001’s electronic care plan and identified that the specified intervention was not included in this resident’s care plan.

The Inspector reviewed the progress notes in resident #001’s health care record and identified a progress note entered by Nurse Manager #106, which indicated that the resident sustained a fall and that a specified intervention was implemented to prevent further falls.

During an interview with PSW #109, they stated that they would reference a resident’s kardex or point of care (POC) for fall prevention interventions. The PSW stated that resident #001 was at risk for falls and that they had fall prevention interventions in place, including the specified intervention that the Inspector had observed.

During an interview with RPN #112, they stated that resident #001 had the specified fall prevention intervention in place. RPN #112 reviewed resident #001’s care plan and progress notes with the Inspector. The RPN stated that resident #001’s specified intervention was not included in the resident’s care plan and that this intervention should have been added to the care plan when it was implemented.

During an interview with Nurse Manager #106, they stated that the specified intervention was included in resident #001’s care plan, but that it was just added to the care plan. The Nurse Manager acknowledged that this intervention should have been added to the resident’s care plan at the time the intervention was implemented. [s. 6. (10) (b)]

Issued on this 13th day of March, 2019

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

Original report signed by the inspector.