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 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_0005	027577-18	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): February 26 - March 1, 2019.

The following intakes were inspected on during this Follow up inspection:

- One intake related to compliance order (CO) #001 that was issued during inspection #2018_745690_0010 for s. 19 (1) of the Long-Term Care Homes Act (LTCHA), specific to the home protecting residents from abuse and ensuring that residents were not neglected by the licensee or staff.

A Critical Incident System inspection #2019_657681_0006 was conducted concurrently with this inspection.

PLEASE NOTE: A Written Notification (WN) related to s. 19 (1) of the LTCHA, 2007, identified in concurrent inspection #2019_657681_0006, was issued in this report.

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:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_745690_0010	681

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. 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 protected from abuse by anyone

and that residents were not neglected by the licensee or staff.

The Ontario Regulation 79/10 (O. Reg. 79/10) defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) report was submitted to the Director related to the improper/incompetent treatment of a resident that resulted in harm or risk to the resident. The CI report indicated that a PSW found resident #001 in an inappropriate condition and that the resident sustained an injury as a result of the incident.

The Inspector reviewed the Point of Care (POC) documentation in resident #001's health care record for a specified 24 hour period. The documentation indicated that the resident was to receive specified care at particular intervals throughout the day.

The Inspector also reviewed the progress notes in resident #001's health care record, which included a progress note that indicated that resident #001 was to receive a specified type of care because the resident was at risk for a specified injury.

Inspector #681 reviewed the home's investigation notes, which included notes from an interview with PSW #118 that occurred on a particular date. The notes indicated that when the PSW was asked if they had provided the specified care to resident #001, the PSW stated that they provided care a specified number of times during their shift and that the care was provided to the resident in a specified manner.

During an interview with PSW #119, they stated that they assisted resident #001 with care near the end of their shift and that they reported to registered staff that the resident still required assistance with a specified type of care. PSW #119 stated that resident #001 was to receive specified care at particular intervals during all shifts.

During an interview with PSW #108, they stated that when they attended to resident #001, they found the resident in an inappropriate condition.

The Inspector reviewed the home's policy titled "Resident Rights – Abuse and Neglect Policy", last reviewed May 4, 2018, which indicated that the abuse or neglect of a resident will not be tolerated by the home and any such conduct on the part of a staff member will result in disciplinary action, up to and including termination.

Inspector #681 reviewed the home's investigation notes, which included a discipline letter addressed to PSW #118. The discipline letter indicated that the PSW received disciplinary action because specified care was not provided to resident #001.

During an interview with Nurse Manager #106, they stated that through the home's investigation, it was determined that resident #001 was to receive care at specified times and that PSW #118 did not correctly provide this care to the resident.

During an interview with the Clinical Nurse Consultant, they stated that the PSW who was assigned to resident #001 was disciplined because care was not correctly provided to the resident.

This finding of non-compliance is further evidence to support the compliance order (CO) that was issued to the licensee on October 10, 2018, during Resident Quality Inspection (RQI) #2018_745690_0010, which had a compliance due date of December 10, 2018. [s. 19. (1)]

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.