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
Apr 4, 2019	2019_565647_0008	006340-19	Complaint

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

JENNIFER BROWN (647)

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): March 28 and 29, 2019.

One intake was completed in the complaint inspection related to alleged neglect.

A Critical Incident System (CIS) report was also inspected (2891-000006-19) as it related to this complaint.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a contracted service provider, Resident, and Substitute Decision Maker (SDM).

During the course of the inspection, the Inspector conducted observations in resident home areas, and care delivery processes, review of the home's policies, procedures, education records, and residents' health records.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director alleging that the home had failed to administer a correct prescribed drug therapy to resident #001. The home had subsequently submitted a Critical Incident System (CIS) report to the Director for improper/incompetent treatment of a resident.

Inspector #647 interviewed resident #001's family member who stated that resident #001 had informed the family that they went to bed during the evening hours of an identified date and woke up several hours later and in distress.

During an interview with resident #001, they recalled the details of this incident and stated that they woke up in the middle of the night in distress, realized that they were not receiving the correct prescribed drug therapy and rang the call bell.

During an interview with Registered staff member #101, they indicated to Inspector #647 that they had responded to the overhead page to attend to resident #001. This Registered staff member indicated that when they arrived to the room of resident #001, they found them to be in distress. The registered staff member had taken the resident's vital signs and observed that they were abnormal, and revealed that the resident had not been receiving their correct prescribed drug therapy.

Inspector #647 reviewed the Physician's order, which indicated that resident #001 required a specific prescribed drug therapy.

Inspector #647 interviewed the Director of Care (DOC) who stated that resident #001 had required this specific prescribed drug therapy. The DOC indicated to Inspector #647 that there had been an investigation completed by the home and it was unclear as to how the prescribed drug therapy had not been provided to the resident as specified by the prescriber. [s. 131. (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 drugs, are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received training in the following additional areas before performing their responsibilities, specifically (b) the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

A complaint was submitted to the Director alleging that the home had failed to administer a correct prescribed drug therapy to resident #001. The home had subsequently submitted a Critical Incident System (CIS) report to the Director for improper/incompetent treatment of a resident.

Please refer to WN #1 for additional details.

During interviews with direct care staff members #100, #102, #103, #105, and #106, they all indicated that resident #001 was required to receive a specific drug therapy.

When Inspector #647 asked these staff members what the process would be to ensure resident #001 received the correct ordered drug therapy, their answers all differed in the way this task would be completed. The staff further indicated to the Inspector that they had never received training on how to complete this task.

During an interview with the contracted service provider who partnered with the home to ensure this specific ordered drug therapy was implemented correctly, they indicated that they had never provided the home with training related to this specific drug therapy. The Inspector provided examples of the answers that had been given by the direct care staff members during interviews on how this task would be completed. The contracted service provider indicated that those examples would not be best practice, however, indicated to the Inspector that this clarification or direction had never been provided to staff.

Inspector #647 interviewed the DOC who indicated that there had been an investigation completed by the home and it was unclear how the specific drug therapy had not been provided to the resident as ordered, however, did confirm during this interview that staff had not received training related to the proper procedure for this drug therapy. [s. 218. 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 all staff receive training relating to a specific drug therapy task before performing their responsibilities, to be implemented voluntarily.

Issued on this 4th day of April, 2019

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

Original report signed by the inspector.