Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2020	2020_782736_0007	001003-20	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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 9-13, 2020, and May 26 and 27, 2020. Off site inspection activities took place March 16-18, 2020; as well as, May 13-14, and May 19-21, 2020.

During the course of this Complaint Inspection, the following log was inspected:

-one log related to a complaint to the Director regarding lack of reporting of responsive behaviours, medication administration and nursing and support services concerns.

A Critical Incident System Inspection #2020_782736_0008 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance resulting in a Compliance Order (CO) related to s. 24 (1) of the LTCHA 2007, was identified in a concurrent inspection, #2020_782736_0008, and was also issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers (NM), Nursing Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) reviewed internal investigation notes, relevant resident health records, relevant staff files, licensee policies and observed the provisions of care.

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)**
- **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	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. 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 abuse of resident by anyone that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

A complaint was submitted to the Director related to the management of responsive behaviours and incidents of resident to resident altercations taking place within the long-term care home.

A review of the home's policy, titled "Critical Incidents", #E-45, last revised May 3, 2019, indicated that any person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred were to immediately report the suspicion and the information upon which the suspicion was based to the Director. The policy further indicated that after business hours, the licensee was to use the emergency contact number and fill out a CIS form first thing the following business day.

Inspector #736 reviewed a report of progress notes in Point Click Care (PCC) for a specific date range, with a focus on Behaviours-Responsive Behaviours, and Incidents.

a) The Inspector noted that on a specific date, resident #006 had displayed a specific responsive behaviour towards resident #007. The progress note further indicated that the incident had a specified effect on resident #007.

The Inspector reviewed the ltchomes.net portal and was unable to locate any Critical Incident (CI) reports in relation to the allegation of physical abuse from resident #006 towards resident #007.

In an interview with the DOC, they indicated that the progress notes indicated that resident #006 had displayed a responsive behaviour towards resident #007, which caused a specific effect to resident #007. The DOC further indicated that the incident between resident #006 and resident #007 should have been submitted to the Director, as an incident of resident to resident abuse, and was not.

In an interview with the Executive Director (ED), they reviewed the progress note related to resident #006's interaction with resident #007 on the specified date. The ED indicated that based on the progress note from resident #006's chart, a CI report should have been submitted to the Director for an incident of resident to resident abuse, and was not.

b) The Inspector noted that on another specific date, resident #003 had indicated to staff members during care that a specific incident had taken place.

The Inspector reviewed the ltchomes.net portal, and was unable to locate any CI reports related to the allegation of sexual abuse from resident #003.

In an interview with Personal Support Worker (PSW) #112, they indicated to the Inspector that the allegation was reported to the Unit Supervisor.

In an interview with Registered Practical Nurse (RPN) #103, they indicated to the Inspector that they had informed Nurse Manager (NM) #110 of what the resident had indicated took place.

In an interview with the ED, they indicated to the Inspector that the home had looked into the allegations brought forward by resident #003, and determined they were unfounded. The ED further indicated that although the allegations of resident #003 were unfounded, the allegation should have been submitted to the Director, and was not.

c) The Inspector noted that on a third specified date, resident #004 alleged that resident #005 had performed an identified action. RPN #108 documented that resident #005 was found in resident #004's room; and described the proximity of both residents.

Additional review of progress notes indicated that resident #004 remained upset about

the incident until three days after the alleged incident took place. Progress notes indicated that resident #004 continued to allege that resident #005 had attempted to perform an identified action when they were in close proximity to each other.

The Inspector reviewed the ltchomes.net portal and was unable to locate any CI reports in relation to the allegation of physical abuse from resident #005 towards resident #004.

In an interview with RPN #108, they indicated to the Inspector that they recalled the allegations between resident #004 and resident #005. The RPN also indicated that they were aware that resident #004 remained upset about the alleged incident in the days after. RPN #108 was unsure if the incident had been reported to the Director, as there had been no signs that an incident had taken place.

In an interview with the ED, they indicated that they were aware of an allegation of abuse. The ED indicated that the incident between resident #004 and resident #005 should have been submitted to the Director as an allegation abuse. [s. 24. (1)]

2. A CI report was submitted to the Director on a specified date in 2019, related to the allegation of neglect of resident #002 by PSW #106.

The Inspector reviewed the licensee's internal investigation notes in relation of the allegation of neglect towards resident #002 by PSW #106. Within the investigation package, the Inspector noted a typed document that listed "Care/Abuse Concerns"; the document indicated that an email had been sent from Nurse Manager #102 eight days before the CI report was submitted to the Director and, according to the document PSW #107 stated that PSW #106 had physically abused resident #008.

The Inspector requested and received a copy of the email from NM #102. The date of the email was eight days prior to the CI report being submitted to the Director, and it was sent to the DOC and NM #109.

The Inspector reviewed the ltchomes.net portal and was unable to locate any CI reports related to the allegation of physical abuse towards resident #008 from PSW #106.

In an interview with NM #102, they indicated that they had met with PSW #107 on the date of the email in 2019. The NM further indicated that based on the email, there was an allegation of staff to resident abuse; however, at the time, the PSW was unable to demonstrate any proof that the abuse had occurred, and therefore, the allegation had not

been immediately reported to the Director.

In an interview with the DOC, they indicated that they had received the email from NM #102 the next day; however, they did not immediately report the allegation of physical abuse of resident #008, as they felt that the PSW who was bringing it forward was not creditable. The DOC did indicate to the Inspector that based on the description of the events, it would have met the definition of physical abuse.

In an interview with the ED, they indicated that based on the email sent from NM #102 to the DOC, there was an allegation of physical abuse towards resident #008 from a staff member, and it should have been immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 18th day of June, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AMANDA BELANGER (736)
Inspection No. / No de l’inspection :	2020_782736_0007
Log No. / No de registre :	001003-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 15, 2020
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 :	Jenny Douma

To Mill Creek Care Centre, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / No d'ordre : 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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with s. 24(1) of the LTCHA.

Specifically, the licensee must ensure that all allegations of resident abuse or neglect are immediately reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that abuse of resident by anyone that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

A complaint was submitted to the Director related to the management of responsive behaviours and incidents of resident to resident altercations taking place within the long-term care home.

A review of the home's policy, titled "Critical Incidents", #E-45, last revised May 3, 2019, indicated that any person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred were to immediately report the suspicion and the information upon which the suspicion was based to the Director. The policy further indicated that after business hours, the licensee was to use the emergency contact number and fill out a CIS form

first thing the following business day.

Inspector #736 reviewed a report of progress notes in Point Click Care (PCC) for a specific date range, with a focus on Behaviours-Responsive Behaviours, and Incidents.

a) The Inspector noted that on a specific date, resident #006 had displayed a specific responsive behaviour towards resident #007. The progress note further indicated that the incident had a specified effect on resident #007.

The Inspector reviewed the ltchomes.net portal and was unable to locate any Critical Incident (CI) reports in relation to the allegation of physical abuse from resident #006 towards resident #007.

In an interview with the DOC, they indicated that the progress notes indicated that resident #006 had displayed a responsive behaviour towards resident #007, which caused a specific effect to resident #007. The DOC further indicated that the incident between resident #006 and resident #007 should have been submitted to the Director, as an incident of resident to resident abuse, and was not.

In an interview with the Executive Director (ED), they reviewed the progress note related to resident #006's interaction with resident #007 on the specified date. The ED indicated that based on the progress note from resident #006's chart, a CI report should have been submitted to the Director for an incident of resident to resident abuse, and was not.

b) The Inspector noted that on another specific date, resident #003 had indicated to staff members during care that a specific incident had taken place.

The Inspector reviewed the ltchomes.net portal, and was unable to locate any CI reports related to the allegation of abuse from resident #003.

In an interview with Personal Support Worker (PSW) #112, they indicated to the Inspector that the allegation was reported to the Unit Supervisor.

In an interview with Registered Practical Nurse (RPN) #103, they indicated to

the Inspector that they had informed Nurse Manager (NM) #110 of what the resident had indicated took place.

In an interview with the ED, they indicated to the Inspector that the home had looked into the allegations brought forward by resident #003, and determined they were unfounded. The ED further indicated that although the allegations of resident #003 were unfounded, the allegation should have been submitted to the Director, and was not.

c) The Inspector noted that on a third specified date, resident #004 alleged that resident #005 had performed an identified action. RPN #108 documented that resident #005 was found in resident #004's room; and described the proximity of both residents.

Additional review of progress notes indicated that resident #004 remained upset about the incident until three days after the alleged incident took place. Progress notes indicated that resident #004 continued to allege that resident #005 had attempted to perform an identified action when they were in close proximity to each other.

The Inspector reviewed the ltchomes.net portal and was unable to locate any CI reports in relation to the allegation of physical abuse from resident #005 towards resident #004.

In an interview with RPN #108, they indicated to the Inspector that they recalled the allegations between resident #004 and resident #005. The RPN also indicated that they were aware that resident #004 remained upset about the alleged incident in the days after. RPN #108 was unsure if the incident had been reported to the Director, as there had been no signs that an incident had taken place.

In an interview with the ED, they indicated that they were aware of an allegation of abuse. The ED indicated that the incident between resident #004 and resident #005 should have been submitted to the Director as an allegation abuse. (736)

2. A CI report was submitted to the Director on a specified date in 2019, related

to the allegation of neglect of resident #002 by PSW #106.

The Inspector reviewed the licensee's internal investigation notes in relation of the allegation of neglect towards resident #002 by PSW #106. Within the investigation package, the Inspector noted a typed document that listed "Care/Abuse Concerns"; the document indicated that an email had been sent from Nurse Manager #102 eight days before the CI report was submitted to the Director and, according to the document PSW #107 stated that PSW #106 had physically abused resident #008.

The Inspector requested and received a copy of the email from NM #102. The date of the email was eight days prior to the CI report being submitted to the Director, and it was sent to the DOC and NM #109.

The Inspector reviewed the ltchomes.net portal and was unable to locate any CI reports related to the allegation of physical abuse towards resident #008 from PSW #106.

In an interview with NM #102, they indicated that they had met with PSW #107 on the date of the email in 2019. The NM further indicated that based on the email, there was an allegation of staff to resident abuse; however, at the time, the PSW was unable to demonstrate any proof that the abuse had occurred, and therefore, the allegation had not been immediately reported to the Director.

In an interview with the DOC, they indicated that they had received the email from NM #102 the next day; however, they did not immediately report the allegation of physical abuse of resident #008, as they felt that the PSW who was bringing it forward was not creditable. The DOC did indicate to the Inspector that based on the description of the events, it would have met the definition of physical abuse.

In an interview with the ED, they indicated that based on the email sent from NM #102 to the DOC, there was an allegation of physical abuse towards resident #008 from a staff member, and it should have been immediately reported to the Director.
The severity of this issue was determined to be a one, as there was no harm or risk to residents. The scope of the issue was a level three, identified as

widespread. The home had a level three compliance history, with one or more non-compliances in the last 36 months, including:
-a Compliance Order (CO) issued January 4, 2018 (2017_420643_0022)
-a Written Notice (WN) issued October 6, 2017 (2017_441110_0007). (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2020

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 15th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Belanger

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