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
Sep 1, 2021	2021_824736_0013	010528-21	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

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

This inspection was conducted on the following date(s): July 27-30, and August 3-5, 2021.

During this inspection, the following log was inspected:
-one log, regarding a complaint submitted to the Director related to an allegation of improper care of a resident that resulted in a transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Nurse Managers, Clinical Practice Coordinator, Office Manager, Environmental Services Manager, COVID-19 Screener, Nurse Consultant, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Housekeeper(s), residents and family members.

During the course of the inspection, the Inspector observed staff to resident interactions, reviewed relevant resident health care records, complaint logs, employee files, licensee policies and procedures, as well as reviewed Infection Prevention and Control practices, and air temperature logs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents plans of care set out clear directions to staff and others who provided direct care to the residents.

Two residents required the use of an assistive device for transferring. There was no direction to staff in the resident's plan of care as to what additional equipment was required.

The Inspector was unable to locate any documentation to indicate that either resident had been assessed for the appropriate additional equipment.

In interviews with multiple staff, no one was able to indicate to the Inspector what additional equipment was required of staff to assist the residents in transferring.

In an interview with the Director of Care (DOC), they confirmed that the residents plans of care did not provide clear direction to staff regarding what additional equipment was required. The DOC indicated that there was risk to the resident if the wrong additional equipment was used.

Sources: The residents care plans, progress notes and assessments; interviews with the RPN, Nurse Manager, Clinical Practice Coordinator, and DOC, as well as other staff; licensee policy titled "Transfers", E-20, last reviewed March 2021, and licensee policy titled "Assessments and Documentation for Lifting, Transferring and Repositioning", O-40, last revised June 2021. [s. 6. (1) (c)]

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 plan of care provides clear direction to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that home maintained a minimum temperature of 22 degrees Celsius on all five home areas.

While reviewing the home's air temperatures, the Inspector noted several occasions where the air temperature measured below 22 degrees on each of the five home areas.

During an observation of a home area, the Inspector noted the temperature to be reading 21 degrees, which was confirmed by the Executive Director (ED).

In an interview with a resident, they indicated that they were cold while sitting in a common area.

In separate interviews with the Environmental Services Manager (ESM) and ED, they both confirmed that there have been times in the home where the temperature was below the required 22 degrees.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Daily temperature logs; Inspector observations;

licensee policy titled "Hot Weather Related Illness", ID G-20, last revised July 5, 2021; interview with resident, ESM, ED and other staff. [s. 21.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

According to the amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements, which was sent April 1, 2021, with an effective date of May 15, 2021, Long-Term Care Home's were required to measure and document the air temperature.

In an interview with the ED, they confirmed that temperatures were not consistently measured and documented in at least two resident bedrooms in different parts of the home, and should have been.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Temperature-Humidity Logbooks; Indoor Air Temperatures and Humidex Monitoring Records; licensee policy titled "Hot Weather-Related Illness", G-20, revised July 5, 2021; interviews with ESM, ED, and other staff. [s. 21. (2) 1.]

3. The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home.

In a review of both the home's air temperatures, it was noted that multiple days the temperatures were not documented in writing in one resident common area on every floor of the home.

In an interview with the ED, they confirmed that air temperatures in one resident common area on every floor of the home was not documented in writing consistently during May, June and July 2021.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements;. Temperature-Humdity Logbooks; Indoor Air Temperatures and Humidex Monitoring Records; licensee policy titled "Hot Weather Related Illness", G-20, last revised July 2021; interviews with ESM, ED, and other staff. [s. 21. (2) 2.]

4. The licensee has failed to ensure that when air temperatures were required to be monitored, the temperatures were documented at least one every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

In a review of the home's air temperatures for a period of three months, it was noted that many temperatures had not been documented at least once every morning, once every afternoon between the designated hours and once every evening and night.

In an interview with the ED, they acknowledged that temperatures were to be documented at least once every morning, once every afternoon between designated times, and once every evening or night. The ED reviewed the temperature logs provided to the Inspector and confirmed that temperatures were not consistently documented during the correct time frames.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements;, Temperature-Humdity Logbooks; Indoor Air Temperatures and Humidex Monitoring Records; licensee Policy titled "Hot Weather-Related Illness", G-20, last revised July 2021; interviews with the ESM, ED, and other staff. [s. 21. (3)]

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 air temperature is above 22 degrees, and that the air temperature is monitored in two resident rooms in different areas of the home, and in a common area on each floor, and that it is taken and documented in the morning, between 12 p.m. and 5 p.m., and once in the evening night, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (11) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the care plan. O. Reg. 79/10, s. 24 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's 24-hour admission care plan was based upon known health conditions, of which the licensee should have been aware of, including interventions.

The resident was known to experience pain upon admission. Staff noted in the admission assessment that the resident was known to have pain.

The resident's care plan did not include a focus for pain, and did not provide interventions to staff related to management and control.

In an interview with the Nurse Manager, they indicated that the care plan for the resident was not based on the resident's health conditions, including pain, and should have been.

Sources: The resident's progress notes, eMAR, assessments and care plan, as well as

consultation notes; licensee policy titled "Admissions, Transfers and Discharges", B-05, last revised March 2021, interview with Nurse Manager #120, and other staff. [s. 24. (2) 6.]

2. The licensee has failed to ensure that the resident's 24-hour admission care plan was based on the resident's known skin conditions, and interventions.

When the resident was admitted to the home, it was known that they had a history of skin concerns. During the admission assessment of the resident, the RPN also noted skin concerns.

It was not until eight days after admission, that the potential for skin impairment was added to the resident's care plan.

In an interview with the DOC, they reviewed the resident's care plan, and indicated that the potential for skin impairment and interventions should have been added to the resident's care plan upon admission.

Sources: The resident's progress notes, care plan and admission paper work; licensee policy titled "Skin Care and Wound Management Program", revised March 2021, and policy titled "Admissions, Transfers, and Discharges", B-05, last revised March 2021; interview with DOC and other staff. [s. 24. (2) 7.]

3. The licensee has failed to ensure that the resident's 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator.

a) The resident was admitted to the home from an acute care setting, with specific directions related to the level of assistance required for transferring.

b) The home was provided with information from the placement co-ordinator, that had been completed 21 days prior to admission, which indicated that the resident required a specific device for transferring.

c) In the licensee's policy titled "Admission of a Resident", indicated that the 24-hour care plan must include the type and level of assistance required with ADLs, as well as that the Unit Supervisor was to initiate the Lift/Transfer and Bed Safety Assessment.

The Inspector was unable to locate the Lift/Transfer admission assessment for the resident. In an interview with Clinical Practice Co-Ordinator, it was confirmed that the assessment had not been completed and should have been.

In an interview with the DOC, they indicated to the Inspector that the resident's 24- hour care plan was not based on the resident's assessed needs and preferences, assessments, and information provided by the placement co-ordinator.

Sources: The resident's assessments, and progress notes; "Patient Transfer Record" for the resident; "Placement Assessment LTC" for the resident; licensee policy titled "Admission of a Resident", B-05, revised March 2021; interview with Clinical Practice Co-Ordinator, and DOC, as well as other staff. [s. 24. (4)]

4. The licensee has failed to ensure that the substitute decision maker (SDM) of the resident was given the opportunity to participate fully in the development and implementation care plan.

The resident had sustained an injury and their SDM was not notified until later that day. The resident's injury had increased in severity, resulting in a change of status; however, the SDM was not notified until the following day when the SDM requested a transfer to the hospital.

In an interview with the DOC, they indicated that when the resident sustained the injury and when the resident's status had changed, the SDM of the resident should have been notified so that they could participate in the resident's care plan.

Sources: The resident's progress notes; license policy titled "Pain Management", last reviewed July 2021: interviews with DOC and other staff. [s. 24. (11)]

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 24-hour admission care plan is based on the resident's assessed needs and preferences, and on the assessments, reassessments and information provided by the placement co-ordinator, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting the resident.

The resident was assessed prior to admission to the home for a specific transfer status. Upon admission, the resident was not assessed by the registered staff using the appropriate lift/transfer assessment in Point Click Care (PCC), and no determination was made as to the assistance required or type of lift required for the resident.

The PSW indicated to the Inspector that when the resident had indicated that a specific device was causing discomfort, they used a transfer that the resident had not been assessed for.

In an interview with the Clinical Practice Co-Ordinator, they indicated that registered staff were to complete an assessment of the resident's transfer status using the assessment on PCC, and then communicate the transfer status to the staff involved in the resident's care. The Clinical Practice Co-Ordinator reviewed the resident's assessments and confirmed that the required assessment was not completed upon admission.

In an interview with the DOC, they indicated that staff transferring the resident using the method the PSW indicated, would not be considered a safe transfer for the resident.

Sources: Resident's progress notes, assessments and admission records; licensee policy titled "Assessments & Documentation for Lifting, Transferring and Repositioning", O-40, last revised June 2021; interview with the PSW, Clinical Practice Coordinator, DOC, and other staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, related to hand hygiene for staff and residents, as well as the availability of personal protective equipment (PPE) supplies.

The licensee policy titled "Routine Practices", IFC B-15, last revised December 2020, indicated that hand hygiene was to be completed before preparing, handling, serving,or eating food, and before feeding residents, as well as before and after contact with a resident, and their environment. The licensee policy titled "Additional Precautions", IFC F-05, last reviewed December 2020, indicated that all PPE was to be kept outside the room in an accessible area/cart.

The licensee policy titled "Meal Service Dining Room Meal Service", C-90-10, last revised May 2021, indicated that residents were to be encouraged and assisted to perform hand hygiene when entering and exiting the dining room for meal service.

a) The Inspector observed a staff member collect a dirty dish in the dining room, and then collect clean dishes to deliver to residents, without performing hand hygiene.

b) The Inspector observed a staff member enter a resident's room to deliver an item from the snack cart; the staff member then proceeded to another resident's room without performing hand hygiene.

c) During meal observations, the Inspector noted that residents entering the dining rooms were not consistently offered hand hygiene prior to starting their meal.

d) During an observation on a home area, the Inspector noted that a resident had a contact/droplet precaution sign on their doorway, that indicated that staff were to use goggles or face shields as part of their PPE. The Inspector observed the PPE set up outside the room, and noted that there was no goggles or face shields readily available for staff to utilize when entering the resident's room.

In an interview with both the IPAC lead for the home, and the DOC, they indicated that staff were to complete hand hygiene between residents rooms, and between touching clean and dirty items. They also both confirmed that residents were to be offered hand hygiene prior to meal service. The IPAC lead and Inspector observed the PPE set up for the resident's room together, and the IPAC lead confirmed there was no goggles or face shields available for staff; the IPAC lead indicated that staff would have to go to the clean utility room or to the main floor screening desk to obtain the required PPE.

Sources: Inspector observations; licensee policy titled "Additional Precautions", IFC F-05, last reviewed December 2020, "Routine Practices" IFC B-15, last revised December 2020, and "Meal Service Dining Room Meal Service", C-90-10, last revised May 2021,; interviews with IPAC lead, DOC and other staff. [s. 229. (4)]

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 staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, related to staff use of PPE.

In accordance with COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, effective July 16, 2021, it identified that all staff were required to wear appropriate eye protection (eg., goggles or face shield), when they were within two meters of a resident who was on droplet/contract precautions due to potential or confirmed COVID-19, and staff were to wear a surgical mask at all times.

a) The Inspector noted a staff member entered a resident room that was marked as "droplet/contact precautions". The staff member did not have on any protective eye wear.

b) The Inspector observed an administrative staff member, who was speaking to a resident in a common area, have their face mask looped around one ear, not covering their mouth or nose.

During an interview with the IPAC manager, they indicated that all staff were to use eye protection when entering a resident's room who was on contact/droplet precautions, and were required to wear their mask at all times while interacting with residents.

The improper use of precautionary PPE placed residents at minimal risk of harm.

Sources: COVID-19 Directive #3 for Long-Term Care Homes under the LTCHA, 2007 and issued under Section 77.7 of the HPPA, R.S.O. 1990, c.H.7, in effective as of July 16, 2021; Inspector observations; licensee policy titled "Additional Precautions", IFC F-05, last reviewed December 18, 2020; interviews with the IPAC lead and other staff. [s. 5.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

The resident was noted to have severe pain. The resident later indicated that despite the nurse having administered pain medication, the pain was not relieved.

In an interview with the physician, they indicated that if the resident's pain was not resolved, the physician should have been notified. They acknowledged in this case, the physician was not notified of the increase in pain.

In an interview with the DOC, they reviewed the resident's assessments, and noted that although the resident's pain was not relieved by initial interventions, the resident was not assessed using the clinically appropriate instrument and should have been.

Sources: The resident's progress notes, electronic Medication Administration Record (eMAR), and assessments; licensee policy titled "Pain Management" G-60, last revised March 2021; interview with DOC, physician and other staff. [s. 52. (2)]

WN #8: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determined that the injury had resulted in a significant change in the resident's health condition or remained unable to determine whether the injury had resulted in a significant change in the resident's health condition, informed the Director of the incident no later than three business days after the occurrence of the incident.

The resident was noted to have sustained an injury, that required transfer to an acute care facility. The home staff received reports from the acute care facility, indicating that the resident required further interventions.

The Inspector was unable to locate any reports submitted to the Director related to the resident.

In an interview with the DOC, they indicated that based on the information the home received, a Critical Incident report should have been submitted to the Director.

Sources: The resident's progress notes; reports from the acute care facility related to the resident; policy titled "Critical Incidents", E-45, last reviewed March 22, 2021; interview with DOC, and other staff. [s. 107. (3) 4.]

Issued on this 7th day of September, 2021

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

Original report signed by the inspector.