Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: August 30, 2023
Original Report Issue Date: August 17, 2023
Inspection Number: 2023-1463-0002 (A2)
Inspection Type: Complaint Critical Incident
Licensee: Mill Creek Care Centre
Long Term Care Home and City: Mill Creek Care Centre, Barrie

Amended By	**Inspector who Amended Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.08.30 10:53:49 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Amended Original Report Issue Date: to August 17, 2023.

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Lead Inspector Blake Webster (000689)	**Additional Inspector(s)** Kim Byberg (729)
Amended By Kim Byberg (729)	**Inspector who Amended Digital Signature** Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.08.30 10:54:22 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Amended Original Report Issue Date: to August 17, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11-14, 17-20, 24-27, 2023

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00089074 - 2981-000024-23 related to falls.
- Intake: #00019529, CI#2981-000008-23, Intake: #00084491, CI# 2981-000016-23, and Intake: #0009106, CI# 2981-000031-23 related to improper/inappropriate care.
- Intake: #00091065, CI #2981-000031-23 related to a improper transfer.
- Intake: #00087988, CI# 2981-000022-23 related to neglect.

The following intake(s) were inspected during this Complaint inspection: ·

- Intake: #00088122, IL-13274-SU/ IL-13670-SU/IL-15275 related to falls, medication

management, continence care, food, nutrition, and hydration.

The following intake(s) were completed in this Critical Incident (CI) inspection:
• Intake: #00004803, Intake: #00005058, Intake: #00021264, related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Rationale and Summary
The IPAC Standard for LTCHs, dated April 2022, section 3.1(i), indicated that the licensee shall ensure that surveillance actions were taken to regularly monitor for symptoms or take response to acute illness.

A resident had a history of an acute illness prior to admission to the home. The resident had demonstrated symptoms of the acute illness and had a physician order to collect a specimen sample. Despite demonstration of symptoms on three days over a five-day period staff failed to acquire any specimen collection. The resident was admitted to hospital on the sixth day and diagnosed with the

same acute illness.

The home's Director of Care (DOC) confirmed that Life Labs and Connecting Ontario had not received any specimen samples from that resident during the time frame.

The resident was at risk for delay in treatment of the acute illness when the home did not home did not take appropriate action to collect specimen samples as ordered by the physician.

Sources:
Review of resident's progress notes, physician orders, lab report results, admission referral from home and community care, interviews with DOC and other staff.
[729]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the residents care needs changed or care set out in the plan was no longer necessary.

Rational and Summary
The resident's plan of care stated that they required interventions for falls prevention and management at the time of a fall incident.

The Nurse Manager (NM) stated that the resident no longer required the interventions for falls prevention and management that were in place at the time of incident. They recognized that the care plan should have been updated during that time frame.

The resident's care plan was not reassessed and revised when the resident no longer required the falls prevention and management interventions at the time of incident. This resulted in staff documenting care that was not provided to the resident.

Sources:
Resident's care plan, documentation survey report, interview with NM.
[000689]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

The licensee failed to ensure that an allegation of abuse toward a resident was immediately reported to the Director.

Rationale and Summary
The family of a resident reported allegations of staff to resident physical abuse to the DOC.

The home submitted a critical incident report three days after the incident was reported.

The resident was at low risk of harm when the home did not immediately report to the Director and may have delayed prompt follow up by the Ministry of Long-Term Care (MLTC).

Sources:
Review of the Critical Incident report, Interview with the DOC.
[729]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to comply with the falls prevention and management program when strategies to reduce or mitigate falls, including the implementation of equipment to assist two residents was not in place.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there is a falls prevention and management program that, at a minimum, includes strategies to reduce or mitigate falls, and must be complied with.

Specifically, staff did not comply with the home's policy titled "Fall Prevention Program" revised September 24, 2022, which directed personal support workers (PSW) to ensure that resident call bells were within reach.

Rational and Summary
A) A resident had an injury that resulted in a change in status.

The resident was at increased risk for falls with fall prevention measures not implemented as per their care plan.

The resident was observed sitting in their room without the call bell in reach.

The PSW stated that the resident uses their call bell, and it should have been in reach.

Sources:
Resident progress notes, risk management, care plans, a Critical Incident, investigation notes, observations of resident's room, interviews with PSW and other sources.
[000689]

B) A resident was found on the floor by staff. Prior to the fall, the resident was in their transport wheel-chair and they did not have access to their call bell.

The PSW stated that they did not provide the resident with their call bell after care was provided.

The resident was at risk of harm when they did not have access to their call bell to alert staff that they required assistance prior to their fall.

Sources:
Resident plan of care, progress notes, homes' investigation notes, Fall Prevention Policy, daily management assessment of a fall revised September 24, 2022, page 11. Interview with PSW, NM and DOC.
[729]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that when a resident had fallen, the resident was assessed using a post-fall assessment with a clinically appropriate assessment instrument that was specifically designed for falls.

Rational and Summary
A resident had a fall that resulted in injury. A post falls assessment was not completed at the time of the fall.

The DOC stated that a post falls assessment should have been completed when the resident was found on the floor.

The resident was negatively impacted when there was no post falls assessment completed at the time of incident. The resident suffered an injury that was not properly assessed until the following day.

Sources:
Falls Policy and Procedure, a Critical Incident Report, resident progress notes, care plans, physio assessments, medication administration record, interviews with PSW, DOC and other staff.
[000689]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The licensee failed to ensure that the system to monitor and evaluate the food and fluid intake of a resident with known identified nutritional risk was accurate.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure there was a system to monitor and evaluate the food and fluid intake of residents with identified risks and that the system was complied with.

Rationale and Summary
A resident was at nutritional risk. Their condition deteriorated with acute illness and decreased food and fluid intake which resulted in hospital admission.

The home's policy titled "Nutritional Care, Nutritional Risk of Residents", revised July 19 2022, stated that food and fluid intake of each resident was documented by PSW's in point of care (POC) in the Point Click Care (PCC) software.

The registered staff were to monitor the triggered risk alerts identified from the POC documentation. Any clinical alert related to food and fluid intake was followed up on with appropriate interventions taken and documentation completed. The home's electronic documentation system titled Point Click Care (PCC) was responsible to track and generate alerts to the registered staff when residents' had documented food intake bellow half of regular intake.

The resident had documented intake of meals for three days that should have generated alerts for the registered staff.

The DOC and consultant from Responsive Health Management confirmed that the system should have generated the alert to the registered staff when the resident’s food intake deteriorated.

When the home's system did not generate an alert related to a change with the resident’s food intake, a referral and nutritional assessment were not completed, nor were additional interventions put in place. This may have contributed to the worsening of their acute illness.

Sources:
Review of resident’s food and fluid records and progress notes, point click care look back reports for food intake, PCC alert listing report for the resident, interview with RPN, DOC and Responsive Health Management consultant.
[729]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the Licensee must:
1) Review and revise the Safe Resident Handling Program Policy to include:

a) The person(s) responsible for resident transfer assessments.

b) The person(s) responsible for resident sling assessments.

c) A description of the process for completing sling assessments that includes the type, and size of the sling required for resident use.

d) A description of slings used in the home and methods of application based on manufacturer's instructions.

e) A description of the process for communicating a resident's transfer status to the team.

f) Where sling type and size will be identified/documented.

2) Reassess the resident for their lift and transfer status that includes if required the type and size of sling.

3) Ensure that the residents plan of care for sling size and type aligns with each care plan intervention and is consistent with the residents lift and transfer assessment.

4) Review and revise the home's Lift and Transfer Assessment to include all types and size of slings used by the home.

5) Educate all PSW's, Registered Staff, Physiotherapists and Restorative Therapists on the home's revised Safe Resident Handling Program Policy and Lift and Transfer Assessment, including responsibilities with completing and documenting transfer assessments.

6) Document the education outlined in 5) including the staff members that were educated, the date and person who provided the education. The record of education must be kept in the home.

7) Develop and implement an audit for 3 West to ensure that all residents using a lift are in the correct sling size/type, and the information is included in the residents' plan of care. The audit must include the person completing the audit, the date the audit was completed and any corrective actions in place as a result of identified deficiencies.

8) Develop and implement an audit to ensure there is clear direction for staff to ensure that the home's lift and transfer assessment aligns with the residents care plan/kardex that includes the type and size of sling that three residents requires. The audit must include observations of staff performing transfers for the three residents. Auditing must occur weekly on each resident home area and until compliance is demonstrated for one month. This process must include the date and documentation of observation, and actions taken to address unsafe practices if observed.

Grounds
The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting three residents.

Rational and Summary
A) A resident was being transferred using a specific type of sling. The resident was injured during the transfer.

The Resident's plan of care stated that they required a specific type of sling.

Their plan of care did not have a lift and transfer assessment that included the size and type of sling to be used for transferring with a mechanical lift.

The DOC stated that the resident had a previous change in condition and at the time of incident they no longer met the criteria to use the specific type of sling.

The resident was at high risk for injury when they were not reassessed for safe lift and transfers after they had a change in condition. Furthermore, the form the home used for their lift and transfer assessment prior to, and after the incident did not include an assessment for the correct size or type of sling to be used with a mechanical lift. The home's lift and transfer policy titled "Safe Resident Handling Program" dated July 4, 2022, did not include a process to ensure that the sizing and types of slings were assessed for residents requiring a mechanical lift for transferring.

Sources:
Interview with PSW, RN, Physiotherapist, and DOC. Review of the resident's care plan, progress notes, Lift and Transfer Assessment, physiotherapist assessment, post fall assessment, home's audit for slings, the home's lift and transfer policy titled "Safe Resident Handling Program" dated July 4, 2022.
[729]

B) Staff used improper transferring techniques for a resident resulting in injury.

A PSW stated that during the transfer one part of the transfer device was not attached properly.

The DOC confirmed that it was an unsafe transfer when one part of the transfer device was not attached properly.

Sources:
Falls incident report, a Critical Incident, the residents progress notes, care plans, physio assessments, training records, disciplinary letters, wound assessments, safe operating procedure last revised April 11, 2023, interviews with PSW, DOC and other staff.
(000689)

C) A PSW reported they used a specific transfer device with another PSW to transfer the resident from the floor to their bed. The transfer resulted in an injury to the resident.

The Director of Care (DOC) stated that the specific transfer device used during the incident was not appropriate when transferring a resident off the floor. This would be considered an unsafe transfer.

The resident was negatively impacted when the PSW's failed to use safe transfer devices and techniques. The transfer with the resident resulted in an injury to the resident.

Sources: Falls Policy and Procedure, Hygiene sling instructions, a Critical Incident, residents progress notes, care plans, physio assessments, medication administration record, interviews with PSW, DOC and other staff.
[000689}

This order must be complied with by October 13, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.