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

Original Public Report

Report Issue Date: July 12, 2024

Inspection Number: 2024-1463-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Mill Creek Care Centre

Long Term Care Home and City: Mill Creek Care Centre, Barrie

Lead Inspector	**Inspector Digital Signature**
Dianne Tone (000686)	Dianne Elizabeth Tone Digitally signed by Dianne Elizabeth Tone Date: 2024.07.22 11:54:35 -04'00'

Additional Inspector(s)
Sharon Perry (155)
Alicia Campbell (741126)
Frances Mullen (000864)
Sasha Lee (000866)
Mark Molina (000684)

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 31, 2024 and June 3, 4, 7, 10-14, 18, 19-21, 2024
The inspection occurred offsite on the following date(s): June 7, 18, 2024

The following intake(s) were inspected:

- Intake: #00111605 - related to resident abuse and Late Reporting.
- Intake: #00111638 - Complaint that facility not reporting abuse
- Intake: #00112213 - related to late Reporting of an outbreak
- Intake: #00113251 - Complaint alleging facility not reporting certain matters
- Intake: #00115257 - Complaint related to allegation of abuse of a resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance of Abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect was complied with when they were made aware of an allegation of abuse of resident.

Rational and Summary

The Executive Director (ED) was made aware of an incident alleging abuse. No investigation or assessments were completed at the time and no interventions were provided for the resident.

The home did not follow their policy related to reporting the incident to the Director, the physician, assessment and support of the resident and investigation of the allegation.

When the home did not follow their policy, it delayed appropriate response to an abuse allegation.

Sources: Interview with Personal Support Workers (PSW), Mill Creek Care Centre's Abuse and Neglect.

[000866]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward written complaints concerning care of two residents as required by O. Reg. 246/22 s. 109 (1) stating the licensee is required to immediately forward a complaint to the Director that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

Rational and Summary

A) The home received a written complaint concerning care of a resident.

The home initiated and completed an internal investigation..

The Executive Director stated that the complaint was not reported to the Director.

Sources: Home's Policy, Home's report, Interview with Executive director.

[000686]

B) The home received a written complaint related to care of a resident.

The home initiated and completed an internal investigation..

The Executive Director stated that the incident was not reported to the Director.

Failure to immediately report the allegations of abuse and neglect may have delayed the Director's response.

Sources: Home's Policy, Home's report, Interview with Executive director.
[000686]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, was immediately investigated when the home became aware of the allegation of alleged abuse of resident.

Rationale & Summary:
The Nurse Consultant, Associate Director of Care (ADOC) and Executive Director were aware of an allegation of abuse of a resident, however, the allegation was not immediately investigated.

Not immediately investigating allegations of abuse put other residents at risk as staff continued to work in the home.

Sources: Critical incident (CI), CI investigation notes, email, interview with PSWs Executive Director, RPN.

[000866]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to immediately report improper care of a resident.

Rational and Summary

A Resident was reported to be left on a medical device for a period of time that resulted in a skin injury to the resident.

The home conducted an internal investigation that documented improper care of a

resident that resulted in a skin injury, however they did not report to the Director.

The Executive Director stated that the incident should have been reported to the Director.

Sources: Home's Policy, Home's report, Interview with Executive Director, Resident clinical record.
[000686]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to ensure that when residents had expressed concerns about abuse and neglect, it was not immediately reported to the Director.

Rationale and Summary

A) A resident posted concerns about possible neglect by staff regarding their care on social media .

The home initiated an internal investigation which stated that a resident's social media posts suggested that there may be abuse and neglect related to their care,

and the home had an obligation to report to the Director but did not.

Sources: Interview with ED, Home's report
[000684]

B) A PSW witnessed an alleged incident of abuse by another PSW and the resident was visibly upset and in tears later that day due to the incident.

During an interview, a PSW acknowledged that they did not immediately report the incident. The Executive Director was aware of the incident. This was reported late to the Director.

Sources: Critical Incident Report, Action Line report, home's investigation notes, interview with PSWs, and ED.
[000866]

C) A resident alleged that they were struck by a co-resident that resulted in an area of altered skin integrity to their left forearm.

The home completed an investigation but did not report the alleged abuse to the Director.

Executive Director stated that these incidents of alleged abuse were not reported to the Director.

Failure to immediately report the allegations of abuse and neglect may have delayed the Director's response.

Sources: Home's Policy, Home's investigation, Interview with ED.

[000686]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed when an enteric outbreak was declared.

Rational and Summary

The PHU declared an enteric outbreak on One West unit. The Director was not notified immediately.

The Infection Prevention and Control (IPAC) Lead shared that they were aware of the immediate reporting requirements however, the home did not report the outbreak immediately to the Director.

Sources: Critical Incident Report, interview IPAC Lead.

[000864]

WRITTEN NOTIFICATION: Records, where kept

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 281 (1) 1.
Records, where kept
s. 281 (1) Every licensee of a long-term care home shall ensure that the following records are kept at the home:
1. The records of current staff members.

The licensee failed to ensure that the records of current staff members were retained in the home.

Rational and Summary
The Environmental Service Manager (ESM) shared that their staff completed an orientation checklist at the time of hire. The ESM was not able to provide the completed orientation checklists for two Housekeepers. The ESM said they destroyed the orientation checklists completed at time of hire as they had staff complete a new one each time there were policy changes.

By not having kept the original orientation checklists for employees at the time of hire, the licensee was not able to provide a record showing that staff completed the required education and training as set out in the Fixing Long-Term Care Act, 2021,s. 82(2).

Sources: interview ESM and ED, review of Housekeepers' Staff General Orientation Checklist.

[000864]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1) Develop and implement a written plan to ensure that resident care is continued when staff report off to one another at break time on home area 3 west.

a) Educate PSWs on 3 west on the plan to ensure that resident care is continued when staff report off to one another at break time.

b) Keep a documented record of the education provided, date when the education was completed, the contents of the education and training materials, and by whom.

c) Conduct weekly audits on day shift on 3 west to ensure that the home's plan is being followed. The audits must include a date, indicate any deficiencies, and document any follow up actions completed, the name and designation of the person conducting the audit. The audit will be completed for a one month period or until there are no deficiencies identified.

2) Educate Responsive Health Management Clinical Consultant, Executive Director,

and Acting/Director of Care on the home's zero tolerance of abuse and neglect policy.
a) Keep a documented record of the education provided, date of when the education was completed, the contents of the education and training materials, and by whom.

b) Conduct weekly audits on both 3 West and 3 East home areas to ensure that the home's zero tolerance of abuse and neglect policy is followed for all incidents of alleged, suspected or witnessed abuse. The audits must include a date, record of the incident, indicate any deficiencies, and document any follow up actions completed, the name and designation of the person conducting the audit. The audit will be completed for a two month period or until there are no deficiencies identified.

Grounds
The licensee failed to protect a resident from abuse by a PSW.

For the purpose of this Act and Regulation, “sexual abuse” means: any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

Rationale & Summary
A PSW witnessed another PSW abuse a resident. The PSW did not report what they witnessed.

A resident was observed crying and reported to a PSW that they had been inappropriately touched by a staff member. This was reported to an RPN, charge nurse and nurse consultant.

No investigation was done until twelve days later when the resident reported to the physician that they were inappropriately touched by a PSW and were not feeling well.
The PSW that witnessed the alleged abuse and the PSW that allegedly abused the resident were not immediately interviewed.

After the incident of alleged abuse, the PSW who allegedly abused the resident, continued to work in the home.

Sources: Interviews with resident, PSWs, RPN, and ED, resident's clinical records, home's investigation notes, PSW and nursing staff schedules. [000866]

The Licensee failed to protect a resident from neglect when staff left them on a medical device for an extended period of time resulting in a skin injury.

For the purposes of the Act and this Regulation,
"neglect" means 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 staff member put a resident on a medical device but forgot to take them off resulting in a skin injury.

The ED stated that resident was not provided appropriate care.

Neglecting to provide proper care for a resident resulted in them sustaining a skin injury that required treatment.

Sources: Resident clinical record, Home's policy, Home's investigation, Interviews with ED and RPN/Nurse Manager.

[000686]**This order must be complied with by** September 20, 2024

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.