



Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Aug 28, 29, 30, 31, Sep 4, 5, 6, 10, 11, 14, 17, 20, 2012; 2012_109153_0019; 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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nurse, Physiotherapist, Dietary Aide, Personal Support Workers, Residents and Substitute Decision Makers

During the course of the inspection, the inspector(s) Reviewed clinical health records and home policy and procedures related to Falls Prevention and Responsive Behaviors.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The written plan of care does not set out clear directions for the staff and others who provide direct care to the resident.
 The written plan of care for the identified resident does not provide clear directions as it relates to interventions related to pain management. This was confirmed through interview with the Director of Care.[s.6(1)c]
 (PLEASE NOTE: This finding of non-compliance was found during inspection # 2012_109153_00021)
2. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The resident was not appropriately identified as part of the home's Fall Prevention Program.[s.6(7)]
3. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
 The electronic plan of care for an identified resident did not provide clear direction related to transfer equipment and interventions to respond to responsive behaviors.
 Through interview with the Director of Care it was confirmed the noted interventions were not addressed in the plan of care.[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 a written plan of care for each resident includes clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.



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Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue

Issued on this 4th day of October, 2012

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

Lynn Parsons

