



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Toronto Service Area Office  
5700 Yonge Street, 5th Floor  
TORONTO, ON, M2M-4K5  
Telephone: (416) 325-9660  
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Bureau régional de services de Toronto  
5700, rue Yonge, 5e étage  
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Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 13, 2013	2013_168202_0060	T-469-13	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**

VALERIE JOHNSTON (202)

**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): November 19, 20, 21, 22, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse Managers, Registered Nursing Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed home's policies related to medication administration

The following Inspection Protocols were used during this inspection:



Medication
Pain
Personal Support Services
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

Table with 2 columns: Legend and Legendé. Title: NON-COMPLIANCE / NON - RESPECT DES EXIGENCES. Content includes definitions for WN, VPC, DR, CO, WAO and a detailed description of non-compliance with LTCHA requirements.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).



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**Findings/Faits saillants :**

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s.131(1)]

A review of resident #001's clinical records for an identified period of time, revealed that resident #001 had been administered medications that had not been prescribed to the resident on three identified dates. On two of the identified dates resident #001 was sent to hospital for further assessment and admitted to the critical care unit for significant medical concerns. The Director of Care confirmed in an interview that the medications received by resident #001 on the above dates had not been prescribed for the resident.

***Additional Required Actions:***

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

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**WN #2: 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).**

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**Findings/Faits saillants :**



1. The licensee failed to 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. [s.52(2)]

A review of resident #001's progress notes for an identified period of time revealed that resident #001 had complained of excruciating pain. On an identified date the physician ordered pain medication to be administered as initial intervention. A review of resident #001's medication administration records for the identified period of time revealed that resident #001 received the initial pharmaceutical intervention. An interview with an identified Nurse Manager confirmed that resident #001's pain on the above identified dates had not been assessed by a clinically appropriate assessment instrument. [s. 52. (2)]

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**WN #3: 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):**

**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director is informed no later than one business day of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital. [s.107. (3) 5]

A review of resident #001's clinical records revealed that on an identified date this resident received resident #006's medications, was sent to hospital for further assessment and admitted to the critical care unit for significant medical concerns. An interview with the Director of Care confirmed that the home did not inform the Director of resident #001's adverse drug reaction in respect of which resident #001 was taken to hospital on an identified date.[s. 107. (3) 5.]



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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
    - (i) that is used exclusively for drugs and drug-related supplies,**
    - (ii) that is secure and locked,**
    - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
    - (iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
  - (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked. [s.129 (1) (a)(ii)]

During the course of this inspection observations were conducted throughout the home which revealed: on November 20, 2013 between 10:15 hours and 10:45 hours, a treatment cart storing prescribed medicated creams was unlocked and unattended in the center hallway. An interview with an identified Registered Practical Nurse (RPN) confirmed that the treatment cart storing prescribed medicated ointments was unlocked and should not have been left in the center hallway of the resident care area accessible to residents. [s. 129. (1) (a) (ii)]



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Inspection Report under  
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Homes Act, 2007

Ministère de la Santé et des  
Soins de longue durée

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

Issued on this 19th day of December, 2013

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

Valerie Johnston



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
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

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : VALERIE JOHNSTON (202)

Inspection No. /

No de l'inspection : 2013\_168202\_0060

Log No. /

Registre no: T-469-13

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : Dec 13, 2013

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 : *Karrie Warner.*

To MILL CREEK CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
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  
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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. Please submit plan to [valerie.johnston@ontario.ca](mailto:valerie.johnston@ontario.ca) by December 30, 2013.

**Grounds / Motifs :**

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s.131(1)]

A review of resident #001's clinical records for an identified period of time, revealed that resident #001 had been administered medications that had not been prescribed to the resident on three identified dates. On two of the identified dates resident #001 was sent to hospital for further assessment and admitted to the critical care unit for significant medical concerns. The Director of Care confirmed in an interview that the medications received by resident #001 on the above dates had not been prescribed for the resident. (202)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Jan 31, 2014





Ministry of Health and  
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Ministère de la Santé et  
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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

### **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 or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



**Ministry of Health and  
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**Order(s) of the Inspector**  
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Homes Act, 2007*, S.O. 2007, c.8

**Ordre(s) de l'inspecteur**  
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de soins de longue durée*, L.O. 2007, chap. 8

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and 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](http://www.hsarb.on.ca).



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de soins de longue durée*, L.O. 2007, chap. 8

## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 13th day of December, 2013**

**Signature of Inspector /**

**Signature de l'inspecteur :** Valerie Johnston

**Name of Inspector /**

**Nom de l'inspecteur :** Valerie Johnston

**Service Area Office /**

**Bureau régional de services :** Toronto Service Area Office