Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 2014	2014_369153_0002	T-073-14	Resident Quality Inspection

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), BARBARA PARISOTTO (558), ERIC TANG (529)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 26, 27, 28, 29, 30, June 2, 3, 4, 5, 6, 9, 2014.

During the course of the inspection, the inspector(s) spoke with acting administrator, director of nursing (DON), nurse practitioner (NP), nurse manager (NM), associate nurse managers (ANM), programs manager, food service manager (FSM), registered dietitian (RD), environmental services manager (ESM), manager of clinical informatics, social service coordinator, staff development coordinator, volunteer coordinator, pharmacist, physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cook, dietary aide (DA), physiotherapy assistant (PTA), restorative care, housekeeper, laundry aide, nursing administrative assistant, receptionist, family and residents.

During the course of the inspection, the inspector(s) reviewed clinical health records, nursing staff schedules, equipment and housekeeping cleaning schedules, Resident and Family Council minutes, food committee minutes, food temperature logs, drug destruction records, environmental service log records, staff training records, immunization records, home investigation documentation and home policies related to infection control, medication management, food and nutrition, fall prevention, continence care, skin and wound, abuse, care planning, restraints, private caregiver, staffing plan and replacement; completed observations of staff to resident interactions, resident to resident interactions, meal service, administration of medications, provision of care, air temperatures, potential entrapment zones; conducted tour of the home.

The following critical incident log was inspected: T-161-14.
The following complaint logs were inspected: T-676-13, T-485-14.
The following follow-up logs were inspected: T-730-13, T-757-13.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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.) 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report the allegation of abuse to the Director immediately.

LTCHA s.24(1) was previously issued in the following inspections:
- #2011_103164_0004 dated October 22, 2011, with a Written Notification
- #2012_109153_0016 dated July 27, 2012, with a Written Notification and Voluntary Plan of Correction

During a resident interview in stage 1, resident #010 revealed an allegation of verbal abuse by a staff member that had been reported to the home last year. Resident #010 reported the situation to an identified staff and an internal investigation was initiated immediately. Review of the home's internal investigation revealed that an identified PSW yelled at resident #010, when the resident requested assistance. Through interviews with the ANM and the DON and a record review it was confirmed the licensee did not immediately report to the Director. Both the ANM and the DON agreed the incident should have been reported immediately. [s. 24. (1)]

Additional Required Actions:

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

WN #2: 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 failed to ensure the home is a safe environment for its residents.

During the stage 1 observations, resident #001 and resident #003 were noted to have a gap between the end of the mattress and the headboard of the bed.
The gap in the case of both residents' beds was 10 centimeters.
On June 8, 2014, at 10:20a.m. the ESM and the maintenance staff visited the identified residents' rooms to review the concern and confirmed the mattress keepers were not in place to prevent the mattress from sliding down to the foot board causing the gap between the end of the mattress and the headboard.
During the inspection the home completed an audit of all beds and measures were implemented to ensure mattress keepers were engaged to prevent the mattresses from sliding down.
The ESM met with nursing staff on all units to provide direction to staff regarding the use of the mattress keepers. [s. 5.]

2. On June 4, 2014, at 5:02p.m. the inspector observed the door to the 3 east shower room was propped open with a garbage can and a caution sign was placed outside the door. On June 6, 2014, at 5:10p.m. the 3 east shower room door was ajar. No staff were supervising the area at either time.
Interviews with a RPN and laundry aide confirmed that the shower and tub room doors are to be closed and locked. An interview with NM confirmed the shower and tub room doors are to be closed and locked when unmonitored by staff. [s. 5.]

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;
- all mattress keepers are in place and engaged
- all doors leading to bathing facilities are closed and secure, to be implemented voluntarily.

WN #3: 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

a) The plan of care for resident #013 in relation to dental care provided conflicting information.
A record review indicated under the oral care section that the resident has own teeth while the personal hygiene section indicated the resident has no teeth.
When interviewed the DON and RD confirmed the written plan of care does not provide clear direction to staff and others who provide direct care.

b) A review of the written plan of care for resident #007 provides conflicting information related to bathing preference and frequency as described below:
- resident requests one bath a week
- shower to be given on Mondays and Thursdays on the day shift
- prefers bath.
When interviewed the resident indicated a preference for a bath.
An interview with the DON confirmed the written plan of care does not provide clear direction to direct caregivers related to bathing preference and frequency.

A review of the written plan of care for resident #007 related to mobility and transfer revealed the following information:
- resident can weight bear
- requires a full mechanical lift for transfers
- needs one person total assist with wheelchair.
Interviews with staff confirmed resident #007 is unable to weight bear.

c) A review of the care plan kardex for resident #010 related to mouth care directs staff to provide repetitive cues/intermittent physical assistance.
A review of the resident assessment protocol (RAP) identified the following:
- no teeth
- does not wear dentures
- the tongue requires brushing to remove coating
- resident requires encouragement, cueing and physical assistance with mouth care.

An interview with a PSW revealed full mouth swabs and mouthwash are used for mouth care for resident #010 and confirmed the care plan kardex does not clearly indicate how to perform mouth care.
An interview with the ANM confirmed the plan of care did not set out clear directions as to the provision of mouth care for resident #010. (558) [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident.

A review of resident #014's Minimum Data Set (MDS) assessment was triggered for a respiratory infection.
A review of the personal health records for resident #014 did not identify a diagnosis of a respiratory infection.
An interview with a RPN revealed the resident was not diagnosed with a respiratory

infection during the assessed time period.
An interview with the manager of clinical informatics confirmed the MDS assessment reflected a coding error. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) A review of the care plan kardex identifies resident #008 prefers to be covered with a duvet with feet left uncovered.
Observations on June 2 and 5, 2014, revealed the resident's feet were covered while in bed. An interview with the resident confirmed a preference to have the resident's feet out from under the duvet. An interview with a PSW confirmed upon observation of the resident's covered feet that care was not provided as specified in the plan.

b) On April 25, 2014, resident #007 was prescribed a treatment for an area of skin breakdown.
A review of the electronic medication record (EMAR) indicated the resident received the treatment as ordered on a daily basis until May 19, 2014.
On May 20, 2014, the EMAR was altered to indicate recording the treatment on Monday, Wednesday and Friday while the written order on the EMAR continued to indicate the resident was to receive a prescribed ointment on a daily basis when the dressing was changed.
A review of the physician orders failed to reveal a change in directions from daily application to Monday, Wednesday and Friday.
A further review of the EMAR revealed that on May 23, 2014, the documentation indicated the resident was sleeping suggesting the treatment was not provided.
There was no documentation in the progress notes or EMAR to indicate the prescribed ointment had been applied as prescribed.
When interviewed the RPN could not recall if the resident received the prescribed ointment as prescribed to the wound bed.
Interviews with the NP, DON and ADOC confirmed an order would have been required from the physician or the NP to change the frequency of the application of the prescribed ointment from daily to Monday, Wednesday and Friday. (153)

c) An order for resident #052 was received from the RD to discontinue one box of a nutritional supplement at 8:00a.m. and 12:00p.m. and provide the nutritional supplement four times a day because the resident consumed the supplement better if offered in smaller quantities from a cup.

The order was not transcribed to the quarterly review provided to the physician for review. As a result the resident did not receive the nutritional supplement as ordered by the RD.
When interviewed the DON confirmed a transcription error had occurred. (153) [s. 6. (7)]

4. The licensee failed to reassess and revise the plan of care when the resident's needs changed or care set out in the plan of care is no longer necessary.

a) A review of the plan of care for resident #001 revealed the following interventions:
- do not leave unattended on the toilet
- provide frequent opportunities for mobility
- turn and re-position resident every two hours when in bed
- change reclining wheelchair position
- re-position resident every two hours when resident is in the wheelchair
- provide cueing and prompting to ensure resident makes attempts at own care before offering assistance.
A review of the annual MDS assessment indicates the resident is not mobile, requires extensive assistance of two staff with bed mobility and total assistance with two staff for transfers.
Interviews with staff revealed the resident requires total care with all activities of daily living. The resident is no longer mobile, requires two staff for bed mobility / re-positioning and no longer uses the toilet for continence care.
The plan of care for resident #001 had not been reassessed and revised to reflect the change in the the resident's needs related to mobility, transfer and re-positioning. (153)

b) A review of resident #009's MDS assessment indicates the use of side rails on a daily basis. A review of the resident's kardex and care plan did not reflect the use of side rails. Observations were made and revealed that the resident used side rails to maneuver and reposition in bed. Interviews with direct care staff, RPN, ANM and DON confirmed that the use of side rails was not present in the resident's kardex and care plan. (529)

c) A review of resident #007's MDS assessment indicated:
- a scheduled toileting plan
- pads or briefs used.
The care plan kardex for resident #007 indicates:

-scheduled toileting plan: requires prompting before and after meals, encouragement required.

An interview with a PSW identified the resident no longer participates in a toileting plan as the resident is incontinent.
An interview with a RPN confirmed the plan of care was not revised to reflect the change in care needs of resident #007. (558) [s. 6. (10) (b)]

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 written plan of care sets out clear directions to staff and others who provide direct care to the residents
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any policy and procedure put in place is complied with.

a) The home's policy titled, male and female cathertization indwelling B-05, revised February 19, 2014, states:
- catheterization will be performed by an RN or RPN, who is proficient with the procedure, on the receipt of a physician's order.

An interview with a RPN revealed the use of a catheter for resident #007.
A review of resident #007's health records revealed in August 2013, the physician discontinued the use of a foley catheter.
A review of the physician's order forms from August 2013 to present failed to identify an order for the use of a catheter.
An interview with an ANM confirmed a physician's order is required in the chart for the use of a catheter.
An interview with the pharmacist confirmed there was no physician order on the digiorder sheet and no indication of an order in the progress notes. (558)

b) The home's policy titled, drug destruction and disposal F-35, revised April 30, 2014, indicates under procedure #3 the following:
- when destroying narcotics or controlled substances(drugs) the following must be recorded:
- date of removal from the drug storage area
- the name of the resident
- prescription number
- the drug's name
- strength and quantity
- the reason for destruction
- the date it was destroyed
- the names of the person who destroyed the drug
- the manner of destruction of the drug.

A review of the drug destruction records for May 7, 2014, revealed there was no quantity recorded for the injectable hydromorphone or the reason for destruction.
A review of the drug destruction records for April 9, 2014, revealed there was no documentation to indicate the reason for the destruction of 27 narcotics or controlled substances.
A review of the drug destruction records for March 12, 2014, revealed there was no documentation to indicate the reason for the destruction of 27 narcotic or controlled medications.

A quick review of the drug destruction records revealed a long time practice of not recording the reason for the destruction.
Interviews with the pharmacist and DON confirmed the required documentation had not been completed on the drug destruction records. (153)

c) The home's policy and procedure titled, bed rails E-05 revised on April 30, 2014, states:
- the resident's care plan is to reflect need and reason for bed rail(s).

A review of resident #010's MDS assessment indicates the use of bed rails on a daily basis. Resident #010's current care plan indicates the bed rail is to be in the up position while in bed but does not indicate the reason for the use of the bed rail. Observations were made and revealed that the resident did use the bed rail to maneuver and reposition in bed. Interviews with a RPN, ANM, and DON confirmed that the home's bed rail policy was not followed as the reason for bed rail use was not in the resident's care plan. (529)

d) The home's policy and procedure titled, head injury routine E-35 revised on April 30, 2014, and reviewed at the unit supervisor meeting on April 25, 2014, states:
procedure #1:
- vital signs are to be checked and recorded for forty-eight hours on electronic progress notes
- every one hour for the first four hours
- every two hours for the next four hours
- every four hours for the next sixteen hours
- every eight hours for the next twenty-four hours.

During a staff interview in stage 1 resident #008 was reported to have fallen. A head injury routine was initiated but not completed for forty-eight hours after the fall.
An interview with the NM confirmed the HIR was not completed for forty-eight hours as per the home's policy.

Resident #015 had an unwitnessed fall. A head injury routine (HIR) was immediately initiated. A review of the health record revealed the HIR had not been documented at the established time periods as per home policy. An interview with the RPN who was required to complete the HIR confirmed that the assessment was not completed as required. Interviews with NM and DON confirmed the HIR should have been completed at the identified time. [s. 8. (1) (a),s. 8. (1) (b)]

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 the following home policies are complied with;
- catheterization
- drug destruction
- bed rails
- head injury routine, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.
During the resident interview in stage 1, resident #010 revealed an allegation of abuse by a staff member that occurred last year.
A review of the home's internal investigation record revealed an identified PSW yelled at resident #010 when the resident requested assistance. Resident #010 reported the situation to an identified staff and an internal investigation was initiated immediately.
When resident #010 was interviewed by management, the resident indicated the identified staff member had yelled and made the resident feel threatened.
Interviews with resident #010 during the inspection confirmed the above incident occurred when the resident requested assistance. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menus are communicated to the residents.

During dining observations on May 26 and 30, 2014, on three identified home areas, the inspector was unable to locate the weekly menus. An observation of the interactive kiosk located in the lobby hallway did not communicate the weekly menu.
An interview with a DA identified that daily menus are posted and weekly menus are not.
An interview with resident #021 identified that menus are normally posted on a computer screen on the wall in the dining room.
An interview with the FSM revealed that menus are communicated to residents on the electronic menu boards in each dining room and these boards have not been in use for two months due to an information technology issue. The FSM stated a paper copy of the weekly menu is posted at the serveries on the steam tables. On a tour of 3 west and 3 east dining rooms the FSM was unable to locate posted menus at the serveries. [s. 73. (1) 1.]

2. The licensee failed to ensure that foods are served at a temperature that is safe to the residents.

On June 2, 2014, at 11:51a.m. prior to lunch on an identified home area, it was revealed by a DA that the temperature of the crab croissant salad was 5C. The DA proceeded to place the sandwiches in the fridge as the DA identified that the desired temperature of cold food items is 4C and under.
At 12:16p.m. the DA took the temperature of the sandwiches and it read 12.7C. The DA admitted the original temperature was about the same. The DA proceeded to place the sandwiches in the freezer.
At 12:22 p.m. the DA took the temperature of the sandwiches and it read 12C. The DA served the sandwiches to the residents.
A review of the food service temperature policy and procedure, DS E-05-25 approved on July 1, 2010, states:
If the food temperature of a menu item does not meet standard (indicated on temperature log), the food service manager (or designate) must be notified immediately.
An interview with the FSM revealed that the DA did not notify the manager immediately. The FSM confirmed that the temperature of the food item served to the residents was not safe. [s. 73. (1) 6.]

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 foods are served at a temperature that is safe to the residents, to be implemented voluntarily.

WN #7: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
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).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after an incident that caused injury to a resident resulting in a transfer to a hospital.

A record review revealed a fall incident for resident #020 resulting in a head injury.
The physician assessed the resident who complained of right sided back pain. The physician observed some bruising over the right ribs and slightly tender over the right ribs with palpation and ordered a chest x-ray.
The resident was sent to hospital related to severe pain.
The resident returned from hospital the following day with a diagnosis of three fractured ribs.
The Ministry of Health received a critical incident report eight days later.
An interview with the NM confirmed the Director was not informed of the critical incident within one business day. [s. 107. (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 the licensee informs the Director no later than 1 business day after an incident which results in a resident injury and transfer to hospital, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there is a documented reassessment of each resident's drug regime at least quarterly.
A review of resident #052's clinical health record revealed a reassessment of the resident's drug regime was completed on October 15, 2013. A further review of the resident's clinical health record revealed a reassessment of the resident's drug regime was next completed on February 24, 2014, which was 132 days after the previous reassessment.

A review of resident #006's clinical health record revealed a reassessment of the resident's drug regime was completed on November 28, 2013. A further review of the resident's clinical health record revealed a reassessment of the resident's drug regime was next completed on March, 2014, which was 101 days after the previous reassessment.
Interviews with the pharmacist and DON confirmed the reassessment of the identified residents' drug regimes were not documented on a quarterly basis. [s. 134. (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 documented reassessment of each resident's drug regime at least quarterly, to be implemented voluntarily.

WN #9: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On May 27, 2014, inspector #153 observed an unlabeled hair brush with strands of hair in an identified tub and shower room.
On June 3, 2014, inspector #558 observed two unlabeled hair brushes with strands of hair in an identified tub and shower room.
The policy and procedure for personal hygiene and grooming D-05 revised April 30, 2014, states:
-residents will have individualized grooming aids such as hair brush and tooth paste. Personal items and grooming aids will be labeled.
An interview with NM confirmed the unlabeled hair brushes present an infection control risk. [s. 229. (4)]

2. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission.

A record review of resident #022 indicated the tuberculin skin test was administered forty-eight days after being admitted to the home in 2011.
A record review of resident #011 indicated the tuberculin skin test was administered twenty-three days after being admitted to the home in 2010.
The NM confirmed that the tuberculin screening for resident #011 and #022 was not completed within 14 days of admission. [s. 229. (10) 1.]

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 each resident admitted to the home is screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is maintained in a safe condition and in a good state of repair.
The following areas of disrepair were observed on May 29, 2014, at 2:45p.m.:
1 west:
- resident room #120 west -wall damage behind rising chair in resident room
- resident room #125 - wall damage on wall beside bed and black scuff marks in resident bathroom
- tub room- yellow stains on the floor in the tub room
2 west:
- tub room yellow stains on tub room floor
2 east:
- shower room- chipped ceramic tile
3 east:
- shower room chipped ceramic wall tile
- tub room yellow stains on tub room floor.
The ESM indicated the staining of the tub room floors was caused as a result of the tub nozzles, that dispense the tub disinfectant, dripping and damaging the floor surface.
A flooring contractor had been contacted and was expected to visit the site that day.
The ESM confirmed the above areas required repair. [s. 15. (2) (c)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A record review revealed that resident #009 experienced a fall. A head injury routine was initiated and completed throughout the night shift.
An interview with a RN identified that the vitals for the overnight period were not documented.
The head injury routine policy and procedure E-35 revised on April 30, 2014, and reviewed at the unit supervisor meeting on April 25, 2014, states:
- vital signs to be checked and recorded for forty-eight hours on electronic progress notes
- vital assessments for this procedure to include: blood pressure, pulse, respiration, pupil reaction, level of consciousness.
An interview with the NM confirmed the head injury assessments for resident #009 were not documented. [s. 30. (2)]

WN #12: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.
The following items were observed to be stored in an identified medication cart on June 4, 2014, at 10:10a.m.
- 1 empty hearing aid box for a resident
- 1 bottle of sea clens
- 1 container of cavilon spray
- 1 package of dressing gauze
- a resident's watch and ring.

The RPN removed the above items from the medication cart.
An interview with the DON confirmed the identified items should not be in the medication cart. [s. 129. (1) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 131. (1)	CO #001	2013_168202_0060	153
O.Reg 79/10 s. 21.	CO #001	2013_168202_0061	153

Issued on this 18th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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) :	LYNN PARSONS (153), BARBARA PARISOTTO (558), ERIC TANG (529)
Inspection No. / No de l'inspection :	2014_369153_0002
Log No. / Registre no:	T-073-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 3, 2014
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 :	Maureen Pauls

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure all allegations of abuse are reported to the Director immediately.
The plan should include but not limited to:
- who will be responsible for completing all of the identified tasks and when the tasks will be completed
- re-educate staff on the policy and procedure to ensure the Director is notified immediately as per the LTCHA in regards to mandatory reports.

The plan is to be submitted via email to inspector- Eric.Tang@ontario.ca by July 11, 2014.

Grounds / Motifs :

1. The licensee failed to report the allegation of abuse to the Director immediately.

a) LTCHA s.24(1) was previously issued in the following inspections:
- #2011_103164_0004 dated October 22, 2011, with a Written Notification
- #2012_109153_0016 dated July 27, 2012, with a Written Notification and Voluntary Plan of Correction

b) During a resident interview in stage 1, resident #010 revealed an allegation of verbal abuse by a staff member that had been reported to the home last year.

c) Resident #010 reported the situation to an identified staff and an internal investigation was initiated immediately.

d) Review of the home's internal investigation revealed that an identified PSW yelled at resident #010 when the resident requested assistance.

e) Through interviews with the ANM and the DON and a record review it was confirmed the licensee did not immediately report to the Director. Both the ANM and the DON agreed the incident should have been reported immediately.
(529)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2014

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

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.

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, 11e 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.

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.

Issued on this 3rd day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNN PARSONS

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