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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2015	2015_157210_0003	T-1713-15	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

SLAVICA VUCKO (210), ANN HENDERSON (559), JUDITH HART (513)

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): January 29, 30, February 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2015.

The following Critical Incident Inspection was completed during this inspection: T-1215-14.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), director of care (DOC),
administrator, physiotherapist (PT), dietary manager, dietary aid, registered dietitian (RD), programs manager, environmental services manager (ESM), maintenance assistant, housekeeping aid, manager of clinical informatics, support services manager, physiotherapist (PT), students, residents, families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2014_369153_0002	559

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. 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Review of the written plan of care for resident #45 does not contain the section for vision and hearing. Review of the admission progress notes at an identified date in 2014, indicated when the resident was admitted he/she came with the son and daughter, and he/she was hearing and visually impaired. Review of the three quarterly assessments (resident assessment instrument-RAI) for 2014, indicated the resident had normal vision, and the hearing was adequate. Review of the clinical record indicated the resident went

for an appointment for hearing check up in 2014, but the vision was not assessed since the admission.

Interview with an identified PSW and registered nursing staff indicated they were not aware that the resident had impaired vision and hearing. [s. 6. (1) (c)]

2. Observations of resident #17 indicated that the resident was sleeping most of the time and that his/her dentures were not inserted for the breakfast meal on three identified dates during the inspection. Observation of the resident by the unit supervisor identified that the resident's tongue had a whitish coating and his/her lips were dry, indicating he/she required additional fluids.

The plan of care identified that the resident would maintain good oral hygiene without assistance over the next 90 days and that he/she would put the dentures in independently but requires staff to apply denture adhesive. Interview with an identified PSW indicated the resident was not able to place his/her dentures independently.

Interview with the unit supervisor confirmed that the mouth care was not identified in the plan of care and the plan of care did not set out clear direction for the resident's oral care and dentures, according to the resident's present needs and ability. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the clinical record, the RAI assessments and written plan of care, for resident #45 indicated the resident assessments were as follows:
Bowel continence:
On an identified date, occasionally incontinent; while the flow sheets for one week indicated only one continent episode and the rest were incontinent; the written plan of care indicate the resident was continent.
On an identified date, occasionally incontinent; while the flow sheets for one week indicated only one continent episode and the rest were incontinent; the written plan of care indicated the resident was continent.
On an identified date, continent; while the flow sheets for one week indicated only one incontinent episode and the rest were continent; the written plan of care indicated the resident was continent.
On an identified date, continent; while the flow sheets for one week indicated only one

incontinent episode and the rest were continent; the written plan of care indicated the resident was continent,

Bladder continence:
On a specified date, frequently incontinent, while the flow sheets for one week indicated all the time incontinence; while the written plan of care indicated the resident was incontinent
On a specified date, frequently incontinent; while the flow sheets indicated nine episodes of incontinence and 10 episodes of continence; while the written plan of care indicated the resident was incontinent.
On a specified date, continent, while the flow sheets indicated 13 episodes of incontinence and five episodes of continence; while the written plan of care indicated the resident was incontinent
On a specified date, continent, while the flow sheets indicated four episodes of incontinence and four episodes of continence; the written plan of care indicated the resident was incontinent.

Interview with the registered nursing staff and manager of clinical informatics confirmed that the RAI assessment, the written plan of care and the flow sheets did not coincide because the staff did not collaborate during the assessments. [s. 6. (4) (a)]

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

Review of the written plan of care for resident #4 indicated that the resident had impaired toileting related to the diagnosis of dementia evidenced by decreased strength, unsteady gait, poor judgment. The interventions described were: "resident wears medium pull-up on days, evenings, medium. green on nights, he/she is on scheduled toileting plan, toilets with supervision, needs one person assistance with changing pads and hygiene. The resident is frequently incontinent - incontinent episodes 2- 3 times per week".

Interview with an identified PSW indicated the resident needs assistance with toileting before and after breakfast and lunch. The resident has had diarrhea two to three months ago when the resident was receiving prune juice from the kitchen, but not anymore.

Interview with another identified PSW indicated the resident needs to be checked hourly

because she tries to go to washroom his/herself, he/she tends to make mess on the toilet and he/she needs assistance with perineal care.

Interview with an identified registered nursing staff confirmed that the above mentioned interventions were not discussed with the registered nursing staff. [s. 6. (4) (b)]

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

Review of the written plan of care, indicated resident #2 required physical assistance by one person with toileting and not to be left unattended while on the toilet.

Interviews with identified PSWs revealed staff take the resident to the toilet and leave the resident unattended. A family interview revealed that they found their family member left on the toilet unattended during more than one occasions.

An identified registered staff member confirmed that the care was not performed as per the written plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Review of the written plan of care for resident #9 indicated the resident was at high risk for falls because of the history of falls. The interventions described were: "apply floor alarm while in bed, ensure it is connected to the nurse call bell system and check every shift to ensure both the call bell and the floor alarm is functioning, report to unit supervisor if the floor alarm is not working, check the resident for proper and non-slip footwear, or barefoot; energy Armor Band, staff to ensure that resident is wearing band, notify unit supervisor if the resident is not wearing band or refuses to wear it, also notify falls care coordinator; ensure environment is free of clutter; ensure seating in dining room is close to entrance/exit; ensure washroom floor is clean and dry; falling leaf program-to identify that the resident is at risk for falls; staff to monitor closely for potential for falls; grab bars as appropriate; provide assistance with all transfers as noted under the transferring care plan; reinforce need to call for assistance; the resident to wear proper and non slip footwear and socks with non slip grips; transfer and change positions slowly".

Review of the clinical record of resident #9 indicated the resident had 13 falls in the last eight months.

Review of the policy Fall Prevention Program, the section for preventative interventions, indicated the following preventative interventions to prevent falls and minimize injuries from falls: hip protectors, use of hip pads and non-slip mats on floors around bed, and maintain very low bed height (mattress 7 to 13 inches off the floor), transfer devices such as transfer pole or E-Z turn disc etc.

Interview with an identified registered staff and falls prevention program coordinator confirmed that the above mentioned falls preventive interventions nor different approaches were tried or implemented for the resident. [s. 6. (11) (b)]

7. Review of the written plan of care for resident #45 indicated the following falls prevention interventions:
"1. Apply bed sensor while in bed and check every shift to ensure it is functioning; initiated six months after admission,
2. Chair alarm when up in wheelchair and check on days and evenings that it is working; initiated during the inspection,
3. Ensure environment is free of clutter; initiated since the admission,
4. Ensure washroom floor is clean and dry; initiated since the admission,
5. The resident to wear proper and non slip footwear; initiated since the admission".

The resident had 11 falls since the admission in 2014.

During the fifth fall, several months after the admission, the resident sustained a fracture, and he/she is not mobile with the walker but uses a wheelchair since then.

Review of the policy Fall Prevention Program, the section for preventative interventions, indicated the following preventative interventions to prevent falls and minimize injuries from falls: hip protectors, use of hip pads and non-slip mats on floors around bed, and maintain very low bed height (mattress 7 to 13 inches off the floor), transfer devices such as transfer pole or E-Z turn disc, etc.

The plan of care was not revised to prevent falls and different approaches have not been considered during the 11 falls the resident had since the admission. [s. 6. (11) (b)]

WN #2: 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 has failed to ensure that the equipment are kept clean and sanitary.

Observations performed during the inspection revealed that resident #8's wheelchair and the foot rest of the wheelchair had multiple food particles. Interview with the registered nursing staff-the unit supervisor confirmed that the wheelchair foot rest was not clean and arrangements were made to be cleaned.

Review of the clinical record for resident #15 indicated the resident was dependent for care for activities of daily living (ADL) and was wheelchair dependent, unable to self-propel. Observation performed during the inspection, revealed white staining on the right and left wheelchair arm, many small and large particles of debris on the foot rest of the wheelchair, dust and hair along the three seat boarders of the lazyboy-type chair, multiple flakes of white debris on the chair's black home-medics cushion, and multiple white tiny flecks of debris covering the top side a navy blue bumper-type pad.

Interview with the unit supervisor and support services supervisor confirmed that the above items were not clean and a request for cleaning was placed.

Review of the clinical record for resident #17 indicated the resident received total care for his/her ADL and was identified as receiving palliative care. He/she can sit in the wheelchair when he/she is able. Observations performed during the inspection, revealed multiple white flakes of debris on the wheelchair seat, white staining on the leg rest, with crumbs and debris in the folds of the wheelchair foot rest. In the resident's room was observed a red colored arm chair with white staining on the seat cushion, chair back and left arm rest.

Interview with an identified PSW confirmed that the wheelchair was not clean and removed the arm chair for cleaning. Observation during the inspection, indicated the arm chair was clean but the wheelchair continued to have debris. The unit supervisor confirmed that the wheelchair was not clean. The support services manager notified maintenance to arrange cleaning. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

During stage 1 the inspector approached resident #2 who was with an identified PSW and the PSW stated the resident was agitated and angry today and the PSW confirmed she was unable to determine why. Resident #2 was identified with compromised communication due to a language barrier.

The identified PSW revealed when the resident was happy staff to communicate through hand motions, however, during periods of agitation and anger like today, resident #2 would verbalize anxieties by muttering in the resident's spoken language, which the PSW could not understand. The PSW identified when she was unable to understand what was going on with the resident, he/she felt bad that he/she was unable to communicate with the resident.

Record reviews and interviews with staff revealed resident #2 spoke and understood a language other than English and experienced great difficulty in understanding or conversing in English language. The PSW revealed he/she had worked in the resident's home area for over a year and to her knowledge no staff can communicate in the resident's language. The following day, the PSW indicated the resident had been diagnosed with an infection.

Interventions in the written plan of care direct staff to use an alternative method of communication to minimize the resident's frustration and anxiety, use a communication/picture book and call family for translation if required.
The PSW confirmed the communication/picture book could not be found and family were not called for translation.

In an interview the nurse manager revealed the home does not use an interpreter service and confirmed the strategies put in place for communication had not been successful. [s. 43.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

On September 11, 2014, the meeting minutes identified the residents had raised concerns regarding the cleanliness of the dining room chairs.
On October 10, 2014, the meeting minutes identified the residents had made suggestions for upcoming events.

An interview with the social service coordinator confirmed the Residents' Council concerns and advice had not been responded to in writing in 10 days. [s. 57. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs include a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

During the record review the inspector identified ten residents whose heights had not been measured annually.
The RD confirmed it is the expectation for staff to measure the height on admission and annually. The RD must have the most recent monthly weight and annual height in order to calculate accurate body mass index and the ideal body weight range of a resident.

The RD confirmed the heights for the identified residents had not been measured. [s. 68. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

Interviews with a member of Residents' Council and the Residents' Council assistant confirmed the menu cycle has not been reviewed by the Residents' Council. [s. 71. (1) (f)]

WN #7: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the meal and snack times were reviewed by the Residents' Council.

Interviews with a member of Residents' Council and the council's assistant confirmed the menu cycle was not reviewed by the Residents' Council. [s. 73. (1) 2.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once every year, a survey is taken of the residents and their families to measure their satisfaction within the home and the care, services, programs and good provided at the home.

Staff interviews and a review of the home's current process for determining satisfaction revealed the home uses the standardized stage 1 questions from abaqis plus two additional questions regarding satisfaction with the facility and likelihood of recommendation by residents and family members.

A record review confirmed the home's current survey is an audit and does not measure satisfaction with all programs and services, such as occupational therapy, physiotherapy, continence care, and skin and wound program. [s. 85. (4) (b)]

WN #9: 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 has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

Observation on unit 2 West, on an identified date and time revealed an opened medication cart in front of the dining room. The RPN was across the dining room administering medication to a resident. The RPN administering the medications confirmed the cart had been left open. [s. 129. (1) (a)]

WN #10: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the clinical record indicated on an identified date in 2015, resident #12 was prescribed a medication, once a day, for seven days. The first dose of the medication was given on time. The last two doses were not administered according to the schedule, but two days later.

Interview with DOC indicated the medication was not given because the medication was sent from pharmacy with the name of another resident on the package, the error was discovered and the medication was discarded in the bin for discarded medications. For the whole week, the resident was receiving the medication from the emergency box, and the last dose that was available was administered on the fifth day.

Review of the clinical record and interview with DOC confirmed the prescribed medication was not administered as prescribed. [s. 131. (2)]

Issued on this 4th day of March, 2015

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

Original report signed by the inspector.