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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2018	2018_745690_0010	024659-18	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

TRACY MUCHMAKER (690), JENNIFER BROWN (647), SHANNON RUSSELL (692), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 17-21 and 24-28, 2018.

Additional logs inspected during this Resident Quality Inspection (RQI) included:

One log related to Compliance Order (CO) #001 from inspection #2017_420643_0022 s. 6 (7) of the Long Term Care Homes Act (LTCHA), 2007, specific to providing care as specified in the plan of care;

One log related to CO #002 from inspection #2017_420643_0022 s. 19 of the LTCHA, 2007, specific to resident to resident abuse;

One log related to CO #003 from Inspection #2017_420643_0022 s. 24 of the LTCHA, 2007, specific to reporting allegations of abuse to the Director;

Two complaints related to care of a resident;

One Critical Incident (CI) report submitted by the home to the Director, related to a fire;

One CI report submitted by the home to the Director related to a respiratory outbreak;

Two CI reports submitted by the home to the Director related to resident falls;

Two CI reports submitted by the home to the Director related to Improper/Incompetent treatment of a resident that results in harm or risk to a resident;

Two CI reports submitted by the home to the Director related to staff to resident abuse;

Three CI reports submitted by the home to the Director related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Consultant, Quality Control Manager, Food Service Manager (FSM), Nurse Manager (NM), Social Service Coordinator, Restorative Care Therapist, Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide (DA), Laundry Aides, Certified Service Worker (CSW) with Behavioral Supports Ontario (BSO), residents and family of residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as

numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **1 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 #003	2017_420643_0022	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_420643_0022	647

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. 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 ensure that residents were protected from abuse by anyone. s. 19 (1).

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

a)A Critical Incident (CI) report, was submitted to the Director on an identified date, in which Personal Support Worker (PSW) #125 observed resident #006 displaying an identified responsive behaviour of a sexual nature toward resident #008, in a common area. A further review of the CI report revealed that resident #006 had a history of the identified responsive behaviour of a sexual nature towards other residents dating back two years, including four incidents in one year, one the next year, and one the following year.

A review of resident #006's electronic progress notes demonstrated that on an identified date, resident #006 went into resident #007's room, and displayed an identified responsive behaviour of a sexual nature toward resident #007. Resident #007 expressed to Registered Practical Nurse (RPN) #127 that this interaction made them feel uncomfortable and they did not want a similar incident to occur again.

A further review of resident #006's electronic progress notes reveled three documented incidents of resident #006 seeking out resident #008 and attempting to engage in an identified responsive behaviour of a sexual nature with them over a period of six days which occurred three weeks prior to the reported incident. A progress note on an identified date, indicated that staff observed resident #006 sitting very close to resident

#008 in a common area displaying an identified responsive behaviour of a sexual nature towards resident #008. On the next day, there was a progress note that revealed that resident #006 was consistently seeking out resident #008. Resident #006 was witnessed to be sitting beside resident #008 in a common area, displaying an identified responsive behaviour of a sexual nature towards resident #008. RPN #127 documented they moved the furniture in the common area to deter the identified responsive behaviour from occurring involving resident #006. A progress note six days later, indicated that resident #006 was attempting to engage in an identified responsive behaviour of a sexual nature towards resident #008 in a common area, and that they would cease the identified responsive behaviour of a sexual nature when staff were looking. Staff moved resident #008 away from resident #006 on multiple occasions that day. Subsequently, there was no evidence of documentation over the next 11 days leading up to the reported incident, indicating actions taken or monitoring of resident #006.

A record review of resident #006, #007 and #008's Resident Assessment Instrument Minimum Data Set (RAI-MDS) indicated that resident #006 and #007 had mild cognitive impairment, and resident #008 had moderate cognitive impairment and impaired memory. Interviews with RPN #127 and Registered Nurse (RN) #105 indicated resident #008 was cognitively impaired.

During an interview with Inspector #692, PSW #125 indicated that on the date of the reported incident, they observed resident #006 sitting in a common area displaying an identified responsive behaviour of a sexual nature towards resident #008. PSW #125 indicated that they removed resident #008 from the area and reported what they observed to RPN #127.

In an interview with RPN #127, they confirmed that they were aware of resident #006's history of displaying the identified responsive behaviour of a sexual nature. They further indicated that resident #006 would seek out cognitively impaired residents. RPN #127 confirmed there were three documented incidents where resident #006 was seeking out resident #008 and attempting to engage in an identified responsive behaviour of a sexual nature. They indicated the only action taken after these three incidents was to continue monitoring resident #006 on an hourly basis.

During an interview with RN #105, they indicated that there were interventions that could have been put in place and that the home should have taken further action after the three incidents of resident #006 seeking out resident #008. RN #105 indicated that with the known history of resident #006's identified responsive behaviours, that the licensee did

not protect resident #008 from resident #006.

In an interview with the Administrator and the Corporate Nurse Consultant from the home, they indicated that the home did not take further action in response to the three previous incidents of resident #006 displaying an identified responsive behaviour of a sexual nature toward resident #008, as resident #008 was not showing signs of distress. The home did not take further action until resident #006 performed a specific action of a sexual nature towards resident #008 on the date of the reported incident.

b) In an interview with Inspector #692, RPN #127 further indicated that they initiated an identified intervention on the date of the incident, for resident #006 to monitor the identified responsive behaviour and the identified intervention was to be completed each shift for a specified time period. RPN #127 confirmed the identified intervention was not completed for 10 shifts and it was the expectation that the identified intervention was to be completed for all shifts in the specified time period.

O. Reg 79/10, r. 54, of the LTCHA (2007), was also issued in relation to this finding. Refer to Written Notification (WN) #4 for details. [s. 19. (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. 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. (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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A complaint was submitted to the Director on an identified date, which described care concerns involving resident #014.

Inspector #690 reviewed resident #014's care plan, specific to their dietary and nutritional needs, which indicated the following:

-Interventions related to assisting and monitoring resident #014 to eat slowly and encourage the resident to swallow after each bite.

-Nutritional interventions to indicate that resident was not able to have anything by mouth because of a medical status, as well as interventions for safe feeding, including being fully upright for all oral intakes and alternating between food and fluids.

-Interventions that resident #014 eats meals in the dining room, provide diet as tolerated, and to use specific eating aides and devices.

Inspector #690 reviewed the home's policy titled "Care Plan and Plan of Care", #C-15, last revised May 4, 2018, which indicated that it was the responsibility of the registered staff to ensure that plans of care reflected each resident's current condition, strengths, abilities, risks, likes and dislikes and that staff assigned to the resident were aware of the specific direction/intervention needed to meet resident's individual needs.

In an interview with Inspector #690, PSW #103 indicated that resident #014 was at risk to safely eat and drink and had specified interventions related to the risk but could not recall if there were changes to the identified interventions. PSW #103 indicated that they would access the kardex to find a resident's current interventions.

In an interview with Inspector #690, RPN #127 indicated that resident # 014 had specified interventions related to the diet texture and could not recall if the interventions had changed. RPN #127 indicated that staff would access the care plan to determine the interventions in place to provide care to resident #014. Together Inspector #690 and RPN #127 viewed resident #014's written plan of care. RPN #127, indicated that the care plan did not provide clear direction to staff.

In an interview with Inspector #690, RN #105 indicated that PSW staff would access the kardex on Point of Care (POC) and that Registered staff would utilize the care plan on Point Click Care (PCC) to find information on resident diet and nutritional interventions. Together Inspector #690 and RN #105 viewed resident #014's care plan and noted separate conflicting interventions. Inspector #690 and RN #105 also reviewed resident #014's kardex on POC, and could not locate one of the specified interventions relating to the nutritional focus. RN #105 indicated that the care plan should have provided clear direction to staff and; resident #014's care plan did not provide clear direction.

In an interview with Inspector #690, the Registered Dietitian (RD), indicated that resident #014 had a specific intervention in place but that intervention had changed when the resident had a change in their health status. Inspector #690 and the RD viewed resident #014's care plan and kardex and the RD indicated that the care plan did not provide clear direction to direct care staff and that it should have.

In an interview with Inspector #690, the Director of Care (DOC) indicated that it was the expectation that the plan of care provide clear direction to direct care staff and that resident 014's care plan did not provide clear direction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was assessed and the plan of care

reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A CI report was submitted to the Director for alleged improper/incompetent treatment of a resident. The report indicated that resident #018 sustained an injury while being provided assistance.

Inspector #627 reviewed the home's investigation notes for the alleged incident which indicated that on a particular day, resident #018 had a specified medical event which resulted in an identified diagnosis and significant change of their health status. Eight days later, PSW #103 was providing assistance to resident #018; whereby, the resident sustained an injury.

Inspector #627 reviewed resident #018's care plan and kardex in effect at the time of the injury and could not identify any focus for the identified diagnosis, or any interventions related to the diagnosis.

Inspector #627 reviewed the home's policy titled "Care Plan and Plan of Care", #C-15, last revised May 4, 2018, which indicated that it was the responsibility of the registered staff to ensure that plans of care reflected each resident's current condition, strengths, abilities, risks, likes and dislikes. Staff assigned to the resident were directed to be aware of the specific direction/intervention needed to meet resident's individual needs.

Inspector #627 interviewed resident #018's Substitute Decision Maker (SDM), who was the enacted SDM for the resident. They stated that they observed the PSW providing assistance to resident without the presence of a specified piece of equipment. The SDM stated that they had been told by a PSW that they were concerned as new staff would not know how to protect the resident from injury while providing assistance without the specified piece of equipment. For those reasons, on the day before the reported incident, the SDM requested alternate assistance for the resident until the specified piece of equipment was available and in place. The SDM stated that the resident had been injured the following day while assistance was provided by staff to resident #018 without the presence of the specified piece of equipment. They further stated that they felt no one had addressed the problem and the resident had been injured.

Inspector #627 interviewed PSW #103 who stated that they were caring for resident #018 on the day of the incident. PSW #103 stated that they were the one providing the assistance to resident #018. They stated that the injury had occurred quickly and that the

resident was unable to react to a specified action and sustained an injury. PSW #103 stated that they were told that resident #018 required a specified piece of equipment and that they may have been told that the resident had a recently identified diagnosis. PSW #103 reviewed the care plan and the kardex in effect at the time of the incident which indicated that the resident needed a specified piece of equipment while receiving care. They were unable to identify any mention of resident #018's recently identified diagnosis or any intervention regarding that diagnosis.

During separate interviews with RN #109 and RPN #127, they stated that a resident's plan of care, including the care plan and kardex, should be updated by the registered staff when a resident had a significant change in health status, such as resident #018 had. After reviewing the care plan in effect at the time of the incident, RN #109 and RPN #127 verified that the care plan and kardex were not updated to reflect the resident's care needs, as there was no mention of the resident's identified diagnosis and no interventions related to the identified diagnosis to prevent further injury to the resident. RN #109 and RPN #127 acknowledged that the care plan and kardex had not been updated to reflect the resident's current care needs.

Inspector #627 interviewed the DOC who stated that a resident's care plan should be reflective of their current needs. The DOC acknowledged that they could have identified resident #018's specified diagnosis in the care plan and the kardex, and this would have improved communication of the resident's current care needs. [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 for each resident sets out clear directions to staff and others who provide direct care to the resident, and that the resident is assessed 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Ontario Regulation (O.Reg.) 79/10 of the Long-Term Care Home Act, 2007, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CI report was submitted to the Director, on an identified date, for an incident which occurred two days prior, alleging improper/incompetent care of resident #017 by staff members. The CI report indicated that resident #017 had an identified substance on their hands while eating dinner and staff refused to clean the resident's hands until after dinner, when they received a shower.

a)Inspector #627 reviewed resident #017's care plan in effect at the time of the incident and noted for the focus of "personal hygiene" that the resident required limited one staff assistance to wash their hands.

Inspector #627 reviewed the home's policy titled "Activities of Daily Living/Personal Hygiene and Grooming", #D-05, last revised May 4, 2018, which indicated that residents were to receive daily assistance according to their needs in all activities of daily living (ADLs) to ensure cleanliness, appropriate grooming, and well-being. PSWs were directed to clean resident's nails daily or when required.

Inspector #627 reviewed the home's policy titled "Resident Rights/Abuse and Neglect Policy", #P-10, last reviewed May 4, 2018, which indicated that abuse or neglect of a resident was not tolerated by the home. The home's policy defined neglect as the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the

health, safety or well-being of one or more residents.

Inspector #627 interviewed PSW #108 who stated that they had been working on the evening of the alleged incident. They stated that RPN #107 had come in the dining room to administer medication, when they noted that the resident had an identified substance on their hands. RPN #107 had asked them (PSW #108) to wash the resident's hands. PSW #108 stated that they had been the only PSW in the dining room, were busy handling food, and had refused to wash the resident's hands as they felt that the RPN could, and should wash the resident's hands prior to administering medications. PSW #108 stated that the RPN had cleaned the resident's fingers with an alcohol swab. PSW #108 acknowledged that resident #107 had finished eating their meal without having their hands washed, and that this constituted neglect.

Inspector #627 interviewed RPN #107 who stated that they had been working on the evening of the alleged incident as the charge RPN. RPN #107 further stated that they had wanted to administer medication to resident #017, when they noticed that the resident's hands were "covered" with an identified substance. RPN #107 stated that they had asked PSW #108 to wash the resident's hands and that PSW #108 had declined and used profanity. RPN #107 stated that they had asked two other PSWs who had also declined and had also used profanity. RPN #107 stated that they had cleaned as much of the identified substance as they could off the resident's hand using alcohol swabs.

Inspector #627 interviewed the DOC who stated that the expectation was for the PSW to wash the resident's hands prior to bringing them to the dining room, and for the RPN to wash the resident's hands when they had noticed the identified substance on resident #017's hands. The DOC acknowledged that not washing resident #017's hands constituted neglect.

b) Inspector #627 reviewed the home's policy titled "Abuse and Neglect Policy",#P-10, last reviewed May 4, 2018, which indicated that "any alleged, suspected or witnessed incident of abuse or neglect is to be made to the Executive Director/designate of the Home (the Executive Director), who will immediately commence an investigation".

Inspector #627 interviewed RPN #107 who indicated that they had made RN #106 aware of the incident involving resident #017 at the end of their shift and that they had notified the DOC the following day, when they had returned to work.

Inspector #627 reviewed the home's investigation notes which included a typed transcript

of an interview between RN #106 and the DOC, seven days after the incident, which indicated that RN #106 had not reported the incident to anyone as they thought that RPN #107 had reported the incident to the DOC.

Inspector #627 interviewed RN #109 who stated that when allegations of neglect or abuse were brought forth, the RN was to inform the manager on call or the DOC immediately.

Inspector #627 interviewed the DOC who stated the incident had been reported to the previous DOC the following day. The DOC acknowledged that the expectation was that the manager on call or the DOC were to be made aware of all allegations of abuse or neglect immediately. [s. 20. (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 the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of

altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A CI report, was submitted to the Director on an identified date; whereby, PSW #125 observed resident #006 displaying an identified responsive behaviour of a sexual nature toward resident #008.

A review of resident #006's clinical record revealed that they had a history of the identified responsive behaviour towards residents dating back two years prior. Progress notes demonstrated that there were four incidents of the identified responsive behaviour in one year, one the next year, and one the following year. In each of the incidents resident #006 was found to be displaying a responsive behaviour of a sexual nature towards residents.

A further record review of resident #006's progress notes revealed that an identified intervention was to be completed and documented to monitor resident #006's identified responsive behaviours each shift for a period of seven days. A review of documentation of the monitoring, for resident #006 demonstrated that there was incomplete documentation on 10 shifts.

During an interview with PSW #125, they indicated staff were to complete the documentation of the identified responsive behaviour for resident #006 for seven days. PSW #125 confirmed there was incomplete documentation for 10 shifts.

In an interview with Inspector #692, RPN #127 indicated they initiated the identified intervention on an identified date, for resident #006 to monitor their identified responsive behaviour and that the documentation was to be completed each shift for a period of seven days. RPN #127 confirmed the intervention was not completed for 10 shifts and it was the expectation that it was to be completed for all shifts.

During an interview with the Certified Service Worker (CSW) with Behavioural Support Ontario (BSO), they indicated that the identified intervention for resident #006 had 10 shifts that were incomplete. The CSW confirmed, with the incomplete documentation, that they would not be able to know if resident #006 was exhibiting the identified behaviours and the frequency of the behaviours.

During an interview with Inspector #692, RN #105 indicated that the plan of care revealed that the identified intervention was to be completed for resident #006 on an

identified date and to continue for seven days, and that it was incomplete for 10 shifts. They confirmed that the identified intervention did not identify the responsive behaviours demonstrated by resident #006.

In an interview with the Administrator and Corporate Nurse Consultant for the home, they confirmed that it was the expectation that the identified intervention was to be completed for resident #006 for a period of seven days, and they confirmed that identified intervention was incomplete. (692) [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances, of an emergency, including fire, unplanned evacuation or intake of evacuees.

A CI report was submitted to the Director regarding a fire that occurred in a specific area of the home the day prior.

Inspector #690 reviewed the home's policy titled "Critical Incidents" INDEX I.D: E-45, last revised September 6, 2018, which indicated under the heading "Critical incident reporting and reports: Regulation, subsection 107 (1)" that the following incidents must be reported to the Director MOHLTC immediately: An emergency, including fire, unplanned evacuation or intake of evacuees.

In an interview with Inspector #690, the Administrator indicated that the fire occurred in a specific area of the home on the day prior to the fire being reported. The Administrator could not say why it was not reported until the next day. They indicated that it should have been reported immediately. [s. 107. (1) 1.]

WN #6: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #627 reviewed a medication incident report which indicated that resident #019 received the wrong dose of a specified medication. The incident report indicated that resident #019 was given 0.5 milligram (mg) of a specified medication instead of 0.125 mg at an identified time.

Inspector #627 reviewed a written Physician's order, written on an identified date, which indicated to "change the specified medication to 0.125 by mouth, twice daily".

Inspector #627 reviewed the electronic medication administration record (EMAR) which indicated that the resident had received the correct dose of medication.

Inspector #627 interviewed RPN #124 who stated that the EMAR had been updated, but they had not noted the change and had given the incorrect dosage of the specified medication.

Inspector #627 interviewed the DOC who acknowledged that RPN #124 had given the wrong dose of medication as the resident's medication strip had not been identified with a dosage change. [s. 131. (2)]

Issued on this 12th day of October, 2018

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY MUCHMAKER (690), JENNIFER BROWN (647), SHANNON RUSSELL (692), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2018_745690_0010
Log No. / No de registre :	024659-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 10, 2018
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 :	Jenny Douma

To Mill Creek Care Centre, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_420643_0022, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the Long Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee shall:

1. Protect resident #008 and all other residents from abuse from resident #006;
2. Reassess resident #006's behaviours and implement strategies to prevent further incidents of resident to resident abuse; and
3. Ensure that all staff responsible for the care of resident #006 are aware of resident #006's identified responsive behaviours and the interventions that are in place to prevent abuse of co-residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone. s. 19 (1).

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

a)A Critical Incident (CI) report, was submitted to the Director on an identified date, in which Personal Support Worker (PSW) #125 observed resident #006 displaying an identified responsive behaviour of a sexual nature toward resident #008, in a common area. A further review of the CI report revealed that resident

#006 had a history of the identified responsive behaviour of a sexual nature towards other residents dating back two years, including four incidents in one year, one the next year, and one the following year.

A review of resident #006's electronic progress notes demonstrated that on an identified date, resident #006 went into resident #007's room, and displayed an identified responsive behaviour of a sexual nature toward resident #007. Resident #007 expressed to Registered Practical Nurse (RPN) #127 that this interaction made them feel uncomfortable and they did not want a similar incident to occur again.

A further review of resident #006's electronic progress notes reveled three documented incidents of resident #006 seeking out resident #008 and attempting to engage in an identified responsive behaviour of a sexual nature with them over a period of six days which occurred three weeks prior to the reported incident. A progress note on an identified date, indicated that staff observed resident #006 sitting very close to resident #008 in a common area displaying an identified responsive behaviour of a sexual nature towards resident #008. On the next day, there was a progress note that revealed that resident #006 was consistently seeking out resident #008. Resident #006 was witnessed to be sitting beside resident #008 in a common area, displaying an identified responsive behaviour of a sexual nature towards resident #008. RPN #127 documented they moved the furniture in the common area to deter the identified responsive behaviour from occurring involving resident #006. A progress note six days later, indicated that resident #006 was attempting to engage in an identified responsive behaviour of a sexual nature towards resident #008 in a common area, and that they would cease the identified responsive behaviour of a sexual nature when staff were looking. Staff moved resident #008 away from resident #006 on multiple occasions that day. Subsequently, there was no evidence of documentation over the next 11 days leading up to the reported incident, indicating actions taken or monitoring of resident #006.

A record review of resident #006, #007 and #008's Resident Assessment Instrument Minimum Data Set (RAI-MDS) indicated that resident #006 and #007 had mild cognitive impairment, and resident #008 had moderate cognitive impairment and impaired memory. Interviews with RPN #127 and Registered Nurse (RN) #105 indicated resident #008 was cognitively impaired.

During an interview with Inspector #692, PSW #125 indicated that on the date of

the reported incident, they observed resident #006 sitting in a common area displaying an identified responsive behaviour of a sexual nature towards resident #008. PSW #125 indicated that they removed resident #008 from the area and reported what they observed to RPN #127.

In an interview with RPN #127, they confirmed that they were aware of resident #006's history of displaying the identified responsive behaviour of a sexual nature. They further indicated that resident #006 would seek out cognitively impaired residents. RPN #127 confirmed there were three documented incidents where resident #006 was seeking out resident #008 and attempting to engage in an identified responsive behaviour of a sexual nature. They indicated the only action taken after these three incidents was to continue monitoring resident #006 on an hourly basis.

During an interview with RN #105, they indicated that there were interventions that could have been put in place and that the home should have taken further action after the three incidents of resident #006 seeking out resident #008. RN #105 indicated that with the known history of resident #006's identified responsive behaviours, that the licensee did not protect resident #008 from resident #006.

In an interview with the Administrator and the Corporate Nurse Consultant from the home, they indicated that the home did not take further action in response to the three previous incidents of resident #006 displaying an identified responsive behaviour of a sexual nature toward resident #008, as resident #008 was not showing signs of distress. The home did not take further action until resident #006 performed a specific action of a sexual nature towards resident #008 on the date of the reported incident.

b) In an interview with Inspector #692, RPN #127 further indicated that they initiated an identified intervention on the date of the incident, for resident #006 to monitor the identified responsive behaviour and the identified intervention was to be completed each shift for a specified time period. RPN #127 confirmed the identified intervention was not completed for 10 shifts and it was the expectation that the identified intervention was to be completed for all shifts in the specified time period.

O. Reg 79/10, r. 54, of the LTCHA (2007), was also issued in relation to this finding. Refer to Written Notification (WN) #4 for details. [s. 19. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 1 as it was isolated. The home had a level 4 compliance history, despite MOH action, non-compliance continues with the original area of this section of the LTCHA that included:
- Compliance Order (CO) issued February 23, 2017, (2016_414110_0008)
- Compliance Order (CO) issued October 6, 2017, (2017_414110_0007)
- Compliance Order (CO) issued January 4, 2018, (2017_420643_0022)

(692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 10, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Tracy Muchmaker

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