Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: November 6, 2023

Inspection Number: 2023-1463-0003

Inspection Type:
Critical Incident
Follow-up

Licensee: Mill Creek Care Centre

Long Term Care Home and City: Mill Creek Care Centre, Barrie

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.11.07 10:58:28 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 26-27, 31, 2023, and November 1-2, 2023.

The following intake(s) were inspected during this Critical Incident (CI) inspection:
- Intake: #00089698, related to an allegation of staff to resident abuse;
- Intake: #00093671, related to fall prevention.

The following intake(s) were inspected during this Follow Up inspection:
- Intake: #00095114/Follow-up #: 1 - High Priority CO #001 / 2023_1463_0002, O. Reg 246/22 s. 40, related to transferring and positioning of residents.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1463-0002 related to O. Reg. 246/22, s. 40 inspected by Kim Byberg (729)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that fall prevention interventions were in place for a resident as specified in their plan of care.

Rationale and Summary
A resident did not have their fall prevention interventions in place during the inspection. Their plan of care stated that they should have the interventions in place for the duration of all three shifts.

Registered Practical Nurse (RPN) #109 stated they should have had the interventions in place and they would provide them with the items as soon as possible.

The Resident was at risk for injury, when their fall prevention interventions were not in place as per their plan of care.
[729]

Date Remedy Implemented: October 31, 2023

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The Licensee has failed to ensure that a resident was protected from emotional abuse from a personal support worker (PSW).

The Ontario Regulation 246/22 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
A PSW was witnessed being verbally aggressive towards a resident twice during an evening shift.

The Resident stated that they were upset by the interaction with the PSW.

The Resident was negatively impacted when the incident occurred and required emotional support and comfort from staff in the home.

Sources: Interview with the resident, PSW's, RPN, and Executive Director (ED). Review of the home's investigation notes.
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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that when there was an allegation of resident abuse towards two residents that the allegations were immediately reported to the Director.

Vicariously liable, section 154 (3) of the FLTCA, 2021 states (3) Where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

A) A PSW witnessed another PSW have a verbal altercation with a resident on two separate occasions during the evening shift. It was reported both times to the Registered Nurse (RN) on duty.

The RN sent an email to the home's Director of Care (DOC) at the end of the evening shift. The email was not received until the following day.

Staff did not report the allegations of abuse immediately to the management of the home or to the Director at the MLTC which resulted in the resident being subjected to further abuse from the PSW.

Sources: Interview with a PSW, and an RN. Review of the home's investigation notes.
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B) A resident had a physical responsive behaviour towards a PSW in the dining room. As a result, the PSW slammed their hands on the table, stood up and was verbally aggressive.

The verbal outburst was witnessed by three PSW's and was not reported immediately to the management of the home or the Director at the Ministry of Long-Term Care.

Staff did not report the allegations of abuse towards a resident immediately to the management of the home or to the Director at the MLTC, and later in the evening resulted in a second resident being subjected to further abuse from the PSW on two separate occasions.

Sources: Interview with PSW's. Review of the home's investigation notes.
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