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
Feb 19, 2013	2013_109153_0001	T-892-11,T-2125-12	Complaint

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive, BARRIE, ON, L4N-0Z3

Long-Term Care Home/Foyer de soins de longue durée

MILL CREEK CARE CENTRE
286 Hurst Drive, BARRIE, ON, L4N-0Z3

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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 31, February 1, 4, 5, 7, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physician, Skin and Wound Care Coordinator, Fall Prevention Coordinator, Registered Nurse (RN), Registered Dietitian, Personal Support Workers (PSWs) and Resident.

During the course of the inspection, the inspector(s) Reviewed health care records and Home policies related to Nutritional Care, Falls Prevention and Skin and Wound Care.
Completed observations related to meal service, staff to resident interactions and the provision of resident care.

The following Inspection Protocols were used during this inspection:
Dining Observation

Falls Prevention

Nutrition and Hydration

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 did not ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of Resident #2 so that their assessments are integrated, consistent with and complement each other.
An assessment was completed by the registered dietitian on October 16, 2012 related to skin breakdown.
The registered dietitian did not implement any new interventions at this time, but requested in writing that nursing notify her if Resident #2's wound healing was delayed.
A review of the physician's notes dated November 9, 2012 indicated that Resident #2 was exhibiting a progressive rash which included the eruption of numerous blisters involving the extremities, trunk and face. These blisters would burst resulting in drainage and open wounds.
The registered dietitian was not notified when the resident's skin condition became more widespread and invasive. Nursing did not collaborate with the registered dietitian in the assessment of Resident #2 to ensure the assessments are integrated, consistent and complement each other. [s. 6. (4) (a)]

2. The licensee did not ensure the care set out in the plan of care was provided to the resident as specified in the plan.
On November 9, 2012 a physician order was received to monitor Resident #2's intake and output.
When interviewed the physician indicated monitoring a resident's intake and output would consist of a daily record of fluids in and fluids out recorded in the health care record for the physician to review.
Upon review of the paper copy intake and output form, which was filed in the clinical health record for Resident #2, it was identified the resident's intake and output had not been recorded.
A review of the progress notes revealed the intake and/or output had not been recorded for Resident #2 on the following shifts:
Days - November 20 and December 5, 2012.
Evenings - November 13, 19, 22, 23, 28, and December 3, 2012
Nights - November 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 27, 28, 29, 30, December 2, 3, 4, 6, 2012. [s. 6. (7)]

3. The licensee did not ensure the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.
A review of the progress notes for Resident #1 revealed several entries where the

resident had difficulty sleeping.
On February 7, 2011 the physician ordered "urine dip (C&S if +)".
A urine specimen was obtained and dipped and found to be positive on February 10, 2011. The urine specimen was transported to a medical laboratory for culture and sensitivity. On February 14, 2011 a report was received indicating the resident had an urinary tract infection along with a list of antibiotics sensitive to treatment.
A review of the health care record failed to reveal that an assessment had been completed or orders received regarding the urinary tract infection.
There was no documentation in the clinical record to indicate the urinary tract infection was reported to the physician and no treatment was initiated. [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:
- care set out in the plan of care is provided to the resident as it relates to monitoring residents' intake and output
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other
- residents are reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to complete a skin assessment by a member of the registered nursing staff for resident upon return from hospital.
Resident #1 returned from hospital.
A review of the progress notes revealed a late entry which indicated the following information:
"Skin - moist and has open areas with wound dressing"
"Trunk -: has wound dressing on right bottom and hip"
"Feet- has pressure ulcer on both outer and inner ankles"
According to the progress notes skin assessments were not completed of the open areas covered by wound dressings on the resident's right bottom and hip upon return from the hospital.There was no indication the wound dressings were removed from the above noted areas and a skin assessment completed.
A registered staff member completed skin assessments 6 days after return from hospital whereby numerous areas of altered skin integrity were identified and were assessed to consist of Stage 1 to Stage 3 areas of skin breakdown.
When interviewed the Skin & Wound Care Coordinator confirmed a skin assessment should have been completed upon return from hospital. [s. 50. (2) (a) (ii)]

2. The licensee did not ensure Resident #2 exhibiting altered skin integrity, including skin breakdown or wounds, received immediate treatment and interventions to reduce or relieve pain and promote healing as required.
A review of the physician orders and emars revealed an order for Benadryl 50 mg every 4 hours when needed for pruritis.
Entries in the progress notes indicated the resident was experiencing itchy skin as a result of the progressive rash and the eruption of blisters.
A review of the emars revealed the resident did not receive Benadryl as prescribed by the physician.
Interviews with staff confirmed the resident complained of discomfort and itchiness. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that Resident #1 was assessed by a registered dietitian who is a member of the staff of the home when the resident exhibited altered skin integrity.
On April 7, 2011 a registered staff member documented a late entry for February 2, 2011 in the progress notes indicating the resident had skin breakdown involving the inner aspect of the left ankle, outer aspect of the right ankle and an area on the right hip.

A review of the clinical health record failed to locate an assessment completed by the registered dietitian when the resident exhibited altered skin integrity as noted by the registered staff member on February 2, 2011.
During an interview with the registered dietitian it was confirmed an assessment by the registered dietitian was not completed when the resident exhibited altered skin integrity on February 2, 2011. [s. 50. (2) (b) (iii)]

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 skin assessment is completed by a member of the registered nursing staff upon return from hospital
- a resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain and promote healing
- residents are assessed by a registered dietitian who is a member of the staff of the home when when altered skin integrity is exhibited, to be implemented voluntarily.

WN #3: 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 did not ensure that the nutrition care and hydration programs include a system to evaluate the food and fluid intake of residents with identified risks related to hydration.
Resident #1 was identified at risk for inadequate fluid intake and dehydration.
The resident's fluid intake was monitored but not evaluated. The recording of each resident's fluid intake is documented as a percentage of fluids consumed.
Resident #1 was assessed by the registered dietitian on January 31, 2011 to require 1760mls of fluid per day.
A review of the fluid intake records from March 15 to April 2, 2011 was completed and calculations of the highest possible amount of fluid consumption were tabulated with the registered dietitian during the inspection.
It was identified that Resident #1 could only have consumed the assessed daily fluid requirements on 3 out of 19 possible days.

The resident was admitted to hospital on April 2, 2011 with a diagnosis of dehydration. [s. 68. (2) (d)]

2. A review of the home's policy titled "Nutritional Assessment and Care" DS C-05-05 under section 11 states;
"It is the responsibility of nursing staff to monitor the food and fluid intake of residents. Nursing staff are to communicate any nutritional changes in residents via a Dietary Nursing Liaison tool."
A referral was not forwarded to the registered dietitian when the resident's fluid intake failed to meet assessed requirements.
When interviewed the registered dietitian confirmed a Dietary Nursing Liaison tool should have been completed when the resident's fluid intake fell below the assess daily fluid requirement. [s. 68. (2) (d)]

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 nutrition care and hydration programs include a system to evaluate the food and fluid intake of a residents with identified risks related to hydration, to be implemented voluntarily.

WN #4: 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. (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 did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission or 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, as follows:
- Resident #1 was admitted on January 26, 2011, received 1st step mantoux on March 25, 2011 and second step on April 14, 2011, both tests were negative.
- Resident #3 was admitted April 20, 2011, received 1st step mantoux on May 22, 2011 and second step on June 1. 2011, both tests were negative. [s. 229. (10) 1.]

Issued on this 12th day of March, 2013

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

Lynn Parsons