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

Division de la responsabilisation et de la performance du système de santé
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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
Nov 18, 2015	2015_334565_0019	024775-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 MARY STREET CREEMORE ON L0M 1G0

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

MATTHEW CHIU (565), ANN HENDERSON (559), BARBARA PARISOTTO (558), DIANE BROWN (110), VALERIE PIMENTEL (557)

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): September 10, 11, 14, 15, 16, 17, 18, 21, 22, 28 and 29, 2015.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection: T-359-14 and T-1132-14.
The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection: T-2899-15, T-2272-15, T-3012-15 and T-1101-14.
The following Follow Up to Order Intake was inspected concurrently with this Resident Quality Inspection: T-1964-15.
During this inspection, the inspector conducted inquiry to Critical Incident Intake log T-469-14.

During the course of the inspection, the inspector(s) spoke with the Director of Administration (DOA), Director of Care (DOC), Associate Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Director of Dietary Services (DDS), Dietary Aide (DA), Cook, Programs Manager (PM), Program Assistant (PA), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Staff, Residents and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 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. 11. (1)	CO #001	2014_171155_0027	110

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. (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 is a written plan of care for each resident that sets out the planned care for the resident.

A review of a Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment for resident #006 revealed a trigger for a specified health condition with no assistive device.
The resident assessment protocol (RAP) revealed the resident health ability related to an identified medical condition and this resident's health condition would be addressed in the care plan.

A review of the written plan of care did not reveal the planned care for resident #006 related to the health condition.
An interview with resident #006 revealed the resident has a medical condition and uses an assistive device when he/she requires. An interview with PSW #116 indicated he/she was unaware that the resident has the health condition and stated the resident does not use the assistive device.
An interview with RPN #106 revealed the resident has the health condition, will use the assistive device some of the time, and stated some identified interventions are implemented.

RPN #106 confirmed the written plan of care for resident #006 did not set out the planned care as it relates to the identified impaired health ability. [s. 6. (1) (a)]

2. The licensee has 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.

Resident and staff interviews revealed a specified soft drink is not readily available for the residents. Observations of the morning tea cart on four identified dates revealed the specified soft drink was not available. Interviews with the following residents and staff members revealed:
- Resident #048, #049 and #051 would like the specified soft drink and it is not offered on the tea carts,
- Resident #050 purchases the specified soft drink as the home does not provide it,
- Resident #052 has a preference for the specified soft drink and staff #100, #117, #125, and #126 revealed the family provides it for the resident. An interview with the family confirmed the purchase of the specified soft drink for an identified period, and assumed the home did not provide it.

A review of the plan of care for the above mentioned residents did not identify the specified soft drink as a preference. An interview with the DOA revealed the specified soft drink is not available on the menu and is available when requested by a resident. An interview with the DDS, by inspector #110, revealed the specified soft drink is available for the residents.

An interview with RPN #117 confirmed the staff and others involved in the different aspects of care did not collaborate with each other in the development of the plan of care

for the above mentioned residents as it related to the provision of the specified soft drink. [s. 6. (4) (b)]

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

A review of the plan of care revealed resident #012 uses an assistive device for meals. A review of the white board located in the dining room servery indicated resident #012 requires an assistive device. On an identified date, the inspector observed the resident without the assistive device at lunch.
An interview with DA #104 revealed resident #012 is usually provided the assistive device. The DA further revealed there was only one available during this meal service and it was provided to another resident. The DA provided a substitution to resident #012.
An interview with the DDS confirmed resident #012 should have the assistive device and the care was not provided as specified in the plan. [s. 6. (7)]

4. Record review of resident #037's plan of care revealed the resident was at risk for falls and had a specified device used for safety.
On an identified date, resident #037 fell and sustained an injury. Record review indicated the fall was unwitnessed, and there was no mention that the specified device was used for the resident.
Interview with PSW #122 revealed he/she discovered the resident lying on the floor and confirmed the specified device was not used for the resident as specified in the plan of care. [s. 6. (7)]

5. Record review of progress notes, care plan, activity of daily living in point of care and the 24 hour report for an identified date revealed resident #056 exhibited responsive behaviours towards PSW #137. The plan of care identified the resident had responsive behaviours and stated specific strategies to be implemented if the resident was resistive to activities of daily living.
An interview with PSW #136 confirmed the resident exhibited responsive behaviours towards PSW #137 during the activities of daily living, and he/she did not implement the specified strategies when providing care to the resident. An interview with the DOA confirmed the home's expectation is to provide care as set out in the plan of care and will be provided to the resident as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan

is no longer necessary.

A review of the plan of care and the physician’s order review for an identified period revealed resident #012 receives a regular texture diet. On an identified date during this period, the inspector observed resident #012 eating a specified texture diet. A review of the white board located in the dining room servery revealed the resident receives the specified texture diet.
A review of the physician's order tab in PointClickCare (PCC) revealed the temporary specified texture diet for resident #012 due to an identified condition.
An interview with the RD revealed this temporary specified texture diet was revised by the RD on an identified date.
A review of the annual care conference notes on the following day revealed resident #012’s identified health condition, the family was notified and an identified health care professional was in to assess the resident. A follow up note seven days later revealed the family informed the home that the resident’s identified health condition had been resolved.

Interviews with the DDS and the RD confirmed when resident #012’s identified health condition was resolved, the intervention of the temporary specified texture diet was not reassessed and the plan of care was not revised when the resident's care needs changed. [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:
1. there is a written plan of care for each resident that sets out the planned care for the resident,
2. 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,
3. care set out in the plan of care is provided to the resident as specified in the plan,
4. the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 residents are protected from abuse by anyone.

Record review of progress notes and critical incident report revealed resident #046 had a history of exhibiting responsive behaviours with residents and staff. PSW #116 observed resident #046 exhibiting a specified responsive behaviour during an interaction with resident #047. PSW #116 intervened and redirected the resident to another home area. Documentation was not completed by staff after the incident.

Record review and an interview with the ADOC confirmed resident #047 would not have been able to give consent.

An interview with the ADOC #114 revealed resident #046 was referred to the Behavioural Support of Ontario (BSO) team for his/her increased responsive behaviours on three identified dates prior to the incident. As a result, interventions for the specified responsive behaviour towards staff members were recommended and implemented.

The ADOC #114 revealed the recommendations were not followed consistently by staff, confirmed the incident occurred and the home failed to protect the resident from abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: 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 are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Record review of progress notes, critical incident report, and interviews with the ADOC #114, RN #138 and PSW #139 revealed resident #046 has a history of exhibiting responsive behaviours with residents and staff.

The resident had been referred to the BSO team on three identified dates.

Staff received collaborative interventions from the mobile support team (MST) to complete a specified charting to track the resident's responsive behaviours.
A review of the MST documentation revealed the resident had six documented incidents of responsive behaviours during an identified period.
Both a physician order and the care plan direct staff to utilize a specific strategy when providing care to this resident.
An interview with PSW #139 confirmed another PSW did not approach the resident with the specified strategy.
The ADOC #114 revealed the specified charting was not completed after the incident on an identified date when resident #046 exhibited responsive behaviours with resident #054.

The ADOC #114 confirmed the identified and implemented interventions had not been consistently followed through by staff. [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 and among residents, including identifying and implementing interventions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy Monitoring of Resident Weights VII-G-20.80 dated January 2015, states the PSW will immediately reweigh any resident with a weight variance (from previous month) of 2kg, record the weight on the appropriate documentation tool and report variances to Registered staff immediately. The RN/RPN will request the PSW reweigh the resident if there is a 2kg difference in resident's weight from the previous month.

a. A review of resident #006's weights revealed a 6.4kg weight variance between two consecutive months in an identified period. A review of PCC documentation and Monthly Weight Report revealed a reweigh had not been taken for resident #006.

b. A review of resident #004's weights revealed a 4.2kg weight variance between two consecutive months in an identified period. A review of the Monthly Weight Report revealed a reweigh had not been taken for resident #004.

Interviews with the RAI coordinator and the PM revealed weights are entered into PCC by the 10th of each month and that nursing staff are aware that reweighs are completed as soon as possible, or on the resident's next bath day.

The PM, who oversees the weight monitoring process along with the RAI coordinator, confirmed a reweigh was not completed and policy was not followed for resident #006 and #004. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy Diet Orders (including Nutritional Supplements) XI-G-20.40 dated January 2015, states the RD will write nutritional supplement orders with the name of the supplement, frequency, amount, and timing and check and update the medication administration records, computerized physician's order and care plan.

A review of the plan of care in an identified period revealed resident #012 received a specified nutritional supplement at two identified times each day. A progress note on an identified date, and created by the RD stated an order for this supplement was in place related to an identified health condition. A review of the physician's order and the physician's digiorder indicated they did not include an order for the nutritional supplement in the identified periods.

An interview with the RD confirmed nutritional supplements require a physician's order and the home's policy was not complied with for resident #012. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

The home's policy in the MediSystem Pharmacy Manual, subject N.&C.S.A.R., Index #04 -07-10, revision date of October 12, 2012, indicated that when a page on the Narcotic and Controlled Substance Administration Record is completed, the nurse who makes the last entry must transfer all the information received from pharmacy to the subsequent page, and is to include original quantity of drug dispensed.

During the review of a drug storage area for narcotics and controlled substances located on an identified home area, the inspector observed on the following records that the information was not transferred for the following residents:
- Resident #057 information for dosage and prescription number of an identified drug,
- Resident #058 information for dosage and prescription number of an identified drug, and
- Resident #059 information for medication, direction, dosage and prescription number of an identified drug.

An interview with RPN #128 and DOC confirmed the information required to be transferred to the subsequent page had not been transferred and the home failed to follow the policy. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone.

On an identified date, resident #056 exhibited responsive behaviours with PSW #137. The staff member continued to provide care and applied a specified excessive physical force to the resident, and it was witnessed by PSW #136.
The incident was reported to RPN #132 by PSW #136. RPN #132 then reported the incident to the RN #115. RN #115 then called the manager on call #140, the manager on call initiated the Critical Incident Report (CI) at an identified time and did not submit the CI or call the ministry action line to inform them of the alleged abuse.

The DOA confirmed the home did not immediately report to the Director the abuse to resident #056. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system must, at a minimum, provide for documentation on the production sheet of any menu substitutions.

The home's policy #XI-E-10.40 Menu substitutions directs the cook/dietary staff to obtain approval for substitutions from the Director of Dietary Services before implementing change.

On an identified date, the inspector observed the pureed menu posted included cinnamon rice pudding and jello, and these desserts were not served.
A review of the food production sheet did not include documentation of the substitutions.
An interview with PSW #100 confirmed the pureed dessert choices offered were pureed rhubarb or banana pudding.

An interview with the DDS confirmed he/she was unaware that dessert changes had been made and staff had not documented the changes on the production sheet, and that the home's policy was not followed. [s. 72. (2) (g)]

WN #7: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure the staff on every shift record symptoms of infection in residents and take immediate action as required.

A review of two identified RAI-MDS assessments revealed resident #005 and #012 had a change in condition and a specified diagnosis respectively.
A review of an identified RAI-MDS assessment revealed resident #008 had a change in condition and a specified diagnosis.
A review of the electronic progress notes revealed registered staff did not record symptoms for:
- Resident #005 on three identified day shifts and one identified night shift,
- Resident #008 on two identified day shifts and one identified evening and night shifts. There was no charting in relation to the specified diagnosis on various shifts of 11 identified days, and
- Resident #012 on three identified day shifts, one identified evening shift and two identified night shifts.

An interview with RPN #117 and the ADOC #114 confirmed it is the expectation registered staff on every shift record symptoms of infection and this had not been done. [s. 229. (5) (b)]

Issued on this 1st day of February, 2016

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

Original report signed by the inspector.