Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_781729_0020	012228-19, 012229-19, 016336-19, 017777-19, 018780-19, 020091-19	Follow up

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 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

KIM BYBERG (729), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 21, 22, 23 and 24, 2019.

Log #012228-19, follow up to compliance (CO) #0016, 2018_773155_0007 related to procedures developed and implemented as part of an organized program of housekeeping services;
Log #012229-19, follow up to CO #0016, 2018_773155_0007 related to the HVAC, heating, ventilation, air conditioning, fire place and residents furnishings are inspected and in good repair;
Log #017777-19, related to transfer resident to hospital with injury causing a change in condition;
Log #020091-19;
Log #016336-19;
Log #018780-19, related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Director of Quality and Informatics (DOQI), Associate Director of Care/RAI Coordinator (ADOC), Scheduling Coordinator, Office Manager, Director of Dietary Services (DDS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Resident Service Coordinator (RSC), Housekeeping, Residents and Families.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed meal service, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, schedules, employee files, home's investigation notes; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **1 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
O.Reg 79/10 s. 87. (2)	CO #016	2019_773155_0007	729
O.Reg 79/10 s. 90. (2)	CO #017	2019_773155_0007	729

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	Légende 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. 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A concern was submitted to the MLTC regarding an allegation of staff to resident abuse. It was reported on a specified date, that resident #002 told PSW #112 they were abused by PSW #113.

The home's policy entitled, 'Prevention of Abuse and Neglect of a Resident', policy # VII-G-10.00, last revised April 2019, stated that anyone who witnessed or had any knowledge of an incident that constituted abuse or neglect, were responsible to immediately take the following steps: stop the abusive situation and immediately inform the Executive Director and/or the Nurse in charge of the care community.

The home's investigation documents for resident #002 stated the home received the complaint on a specified date. However, management were not aware of the reported incident, resident #002 was not assessed, monitored or interventions put in place to ensure the safety and well being of resident #002, and the investigation did not commence until twenty-four hours later.

PSW #112 stated that they told RPN #115 on the specified date, and were directed to call the home the next day and report it to management.

ADOC #101 acknowledged that PSW #112 and RPN #115 did not follow the home's policy in relation to immediate reporting.

The licensee failed to ensure the written policy to promote zero tolerance of abuse was complied with when resident #002 was abused. [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 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, 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 failed to protect resident #002 from abuse by a staff member.

The following is further evidence to support the order issued on October 25, 2109 (A1), during the follow up inspection 2019_781729_0018 with a compliance due date of January 21, 2020. (A1)

A critical incident (CI) submitted to the Ministry of Long Term Care (MLTC) reported an allegation of abuse by PSW #113, towards resident #002 that was reported on a specified date.

The home's investigation notes and interviews stated that on a specified date, resident #002 told PSW #112 that PSW #113 entered their room and had abused them.

Resident #002 shared with inspector #694 that they did not know why PSW #113 did this to them, and the resident described how it made them feel.

PSW #106, told inspector #694 that there were other staff members at the home that alleged they had been abuse by PSW #113. When the staff reported this to DOC #100, PSW #113 was asked to leave the premises. Staff were not aware of any incidents involving residents at that time.

The licensee failed to protect resident #002 from abuse by PSW #113. [s. 19. (1)]

Issued on this 7th day of November, 2019

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

Original report signed by the inspector.