Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2020	2020_781729_0006 (A2)	019707-19, 003415-20	Director Order 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

Amended by KIM BYBERG (729) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

This report has been revised to reflect an extension to the compliance due date. The Director Order Follow-up inspection #2020_781729_0006 was completed on February 24-28, March 2-7, 9-13, 2020.

A copy of the revised report is attached.

Issued on this 23rd day of October, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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Oct 23, 2020	2020_781729_0006 (A2)	019707-19, 003415-20	Director Order Follow Up

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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

Amended by KIM BYBERG (729) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Director Order Follow Up inspection.

This inspection was conducted on the following date(s): February 24, 25, 26, 27, 28, March 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 2020.

A follow up inspection to a Director Order (DO#400 served on 2020-02-26) has concluded that the Director Order was not complied with. An Inspector's Order (CO#001) has been issued for the same non-compliance (r. 53.).

The following intakes were completed in this director order follow up inspection:

-Log #019707-20, Follow up to compliance order #001, 2019_781729_0018 related to responsive behaviours;

-Log #003415-20, Follow up to Director's order #400 related to responsive behaviours.

This inspection is a follow-up to a Director's Order #400, issued by Stacey Colameco as part of a Director Referral.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, s. 53, identified in a concurrent follow-up inspection 2020_781729_0005 log #019707-20 were issued in this report.

Director's Order #400 was served on October 25, 2019.

During the course of the inspection, the inspector(s) spoke with with the Director of Operational Effectiveness (DOOE), Director of Quality and Informatics (DOQI), Executive Director (ED), Director of Care (DOC), Interim Assistant Director of Care (IADOC), RAI Coordinator (RAI), Scheduling Coordinator, Office Manager, Clinical Care Partner, Sienna Menu Planner, Director of Programs and Admissions (DOPA), Director of Environmental and Food Services (DOEF), Resident Service Coordinator (RSC), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Care Support Assistant (CSA), Resident Service Coordinator (RSC), Nexium Agency PSW, Gifted Hands Agency PSW, Housekeeping, Medical Director, Residents and Families.

A follow up inspection to a Director Order (DO#400 served on 2020-02-26) has concluded that the Director Order was not complied with. An Inspector's Order (CO#001) has been issued for the same non-compliance (r. 53.).

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, meeting minutes, schedules, employee files, education records, 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:

Falls Prevention
Responsive Behaviours
Skin and Wound Care
Training and Orientation

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 53. Responsive behaviours

Findings/Faits saillants :

1. The licensee failed to ensure that the strategies to respond to resident #003's responsive behaviours were implemented.

Resident #003 had a history of responsive behaviours. The Behaviour Support Ontario (BSO) community team was involved in resident #003's care and had provided interventions for the home to utilize.

During Inspector 729's observations of care being provided to resident #003, it was observed that resident #003 was displaying the identified responsive behaviours.

Staff member #128 shared that the specified intervention was not provided to resident #003.

Resident #003's plan of care also identified assessments that were to be completed for the resident and they had not been completed.

There was no documentation to support behaviour interventions were tried.

A review of resident #003's plan of care identified the specified intervention was not provided.

The lead for the home's responsive behaviour program #143 shared that they had been working with the BSO team and staff to ensure that interventions of responsive behaviours were implemented. They said that this was not done consistently.

The licensee failed to ensure that the strategies that the home were trialling to respond to resident #003's responsive behaviours with care were implemented. [s. 53.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 23rd day of October, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KIM BYBERG (729) - (A2)
Inspection No. / No de l'inspection :	2020_781729_0006 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019707-19, 003415-20 (A2)
Type of Inspection / Genre d'inspection :	Director Order Follow Up
Report Date(s) / Date(s) du Rapport :	Oct 23, 2020(A2)
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, CREEMORE, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_781729_0018, CO #001; 2019_781729_0018, DO #400;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. Responsive behaviours

Order / Ordre :

The licensee must be compliant with s. 53(4)(a)(b) and (c) of O.Reg 79/10. Specifically, the licensee must:

a) Ensure that actions are taken to respond to the needs of resident #003 and any other resident exhibiting responsive behaviours, including assessments, reassessments and interventions are implemented and that the resident's response to interventions are documented.

Grounds / Motifs :

1. The licensee failed to be compliant with CO #001 from inspection #2019_781720_0018 with a compliance due date amended of January 31, 2020.

The licensee was to be compliant with s. 53(4)(a)(b) and (c) of O.Reg 79/10. Specifically, the licensee was to:

a) Ensure that behavioural triggers for resident #074 and all other residents were identified;
b) Ensure that actions were taken to respond to the needs of resident #073, #074, #014 and #017 and any other resident exhibiting responsive behaviours, including assessments, reassessments and interventions and that the resident's response to interventions were documented;
c) That there was a process in place to monitor the documentation of residents daily to identify any new residents with responsive behaviours and ensure that a plan of care was developed for those new behaviours that included any triggers, and interventions. Ensure that the triggers and interventions were communicated to all

staff and the plan of care was implemented;
d) Develop an auditing tool that specifically evaluated residents experiencing ongoing responsive behaviours to ensure that referrals were completed, and the interventions to manage the responsive behaviours were current and the plan of care for residents was up to date; and
e) Ensure front line staff were involved in the planning, implementation and evaluation of responsive behaviour interventions for resident #073, #074 and all other residents.

The license completed step a), c), d), and e) of compliance order #001.

The licensee failed to ensure that the strategies to respond to resident #003's responsive behaviours were implemented.

Resident #003 had a history of responsive behaviours. The Behaviour Support Ontario (BSO) community team was involved in resident #003's care and had provided interventions for the home to utilize.

During Inspector 729's observations of care being provided to resident #003, it was observed that resident #003 was displaying the identified responsive behaviours.

Staff member #128 shared that the specified intervention was not provided to resident #003.

Resident #003's plan of care also identified assessments that were to be completed for the resident and they had not been completed.

There was no documentation to support behaviour interventions were tried.

A review of resident #003's plan of care identified the specified intervention was not provided.

The lead for the home's responsive behaviour program #143 shared that they had been working with the BSO team and staff to ensure that interventions of responsive behaviours were implemented. They said that this was not done consistently.

The licensee failed to ensure that the strategies that the home were trialling to

respond to resident #003's responsive behaviours with care were implemented. [s. 53.]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 1 as it related to one out of three residents. The home had a level 5 history of on-going non-compliance with this subsection of the Act that included:

Compliance Order (CO) issued August 28, 2018, (2018_742527_0013);
CO issued May 22, 2019, (2019_773155_0007);
CO and Director Referral (DR) issued October 3, 2019, (2019_781729_0018)
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2020(A2)

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 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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 23rd day of October, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KIM BYBERG (729) - (A2)

Ontario

Ministry of Long-Term Care

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Ordre(s) de l'inspecteur

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Service Area Office / Bureau régional de services : Central West Service Area Office